AMA/Specialty Society RVS Update Committee
April 21-24, 2021

Meeting Minutes

I. Welcome and Call to Order

The RUC met virtually in April 2021 due to the COVID-19 pandemic. Doctor Ezequiel Silva, III called the virtual meeting to order on Thursday, April 22, 2021 at 8:30 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

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

RUC Alternates:
Amr Abouleish, MD, MBA
Jennifer Aloff, MD
Amy Aronsky, DO
Gregory L. Barkley, MD
Eileen Brewer, MD
Leisha Eiten, AuD,
Dawn Francis, MD
William F. Gee, MD
David C. Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
S. Kalyan Katakam, MD, MPH
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Eileen Moynihan, MD
Sanjay A. Samy, MD
Kurt A. Schoppe, MD
M. Eugene Sherman, MD
James L. Shoemaker, MD
Clarice Sinn, DO
Holly L. Stanley, MD
Michael J. Sutherland, MD
Donna Sweet, MD
Deepali Nivas Tukaye, MD, PhD
Mark T. Villa, MD
David Wilkinson, MD, PhD
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

Doctor Silva introduced himself as the new Chair of the RUC, appointed March 1, 2021. He stated that he has served as both an Advisor and RUC member prior to assuming the position of RUC chair. He explained the history, composition, and significance of the RUC.

Doctor Silva welcomed everyone to the virtual RUC Meeting. He thanked participants for their time and patience. He reminded participants of RUC confidentiality provisions, general expectations for the virtual meeting (live video), and highlighted points of conference call etiquette.

- Doctor Silva 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.
  - Recording devices are prohibited.
  - The full confidentiality agreement may be found on the RUC Collaboration site (Structure and Functions).

- Doctor Silva conveyed the following RUC Member information:
  - The RUC assumes that RUC members are "seated." Once seated for a tab, the RUC member must stay in the seat for the entire issue until completion with vote.
  - If an Alternate replaces a RUC member during the virtual meeting, they must announce as the RUC transitions to a new issue. The Alternate may do this by using the "raise hand" option.
  - RUC staff recommends using the view "side-by-side" under view options at the top in order to view shared documents with "speaker" view.

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff:
  - Perry Alexion, MD - Medical Officer
  - Arkaprava Deb, MD - Medical Officer
  - Edith Hambrick, MD, JD, MPH - Medical Officer
  - Scott Lawrence - Acting Deputy Director, Division of Outpatient Care
  - Karen Nakano, MD - Medical Officer
  - Gift Tee, MPH - Director, Division of Practitioner Services
  - Pamela Foxcroft Villanyi, MD - Medical Officer

- He also noted that a number of CMS observers were present for the virtual meeting.

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

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

- Doctor Silva wished a fond farewell to the longest serving RUC member:
  - David Hitzeman, DO *(25 years of service)*

- Doctor Silva announced new RUC Members:
  - Sergio Bartakian, MD (SCAI)
  - Joseph Cleveland, MD (STS)
  - Daniel DeMarco, MD (ACG)/(AGA)/(ASGE)
  - William Donovan, MD (ACR)
  - Matthew Grierson, MD (AAPM&R)
  - Richard Rausch, DPT, MBA (HCPAC Co-Chair)

- Doctor Silva announced new RUC Alternate Members:
    - Leisha Eiten, AuD, CCC-A (HCPAC Alternate Co-Chair)
    - Dawn Francis, MD (ACG)/(AGA)/(ASGE)
    - Sanjay A. Samy, MD (STS)
    - Kurt Schoppe, MD (ACR)
    - Clarice Sinn, DO (AAPM&R)
    - Deepali N. Tukaye, MD, PhD (SCAI)

- Doctor Silva conveyed the Lobbying Policy:
    - "Lobbying" means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
    - Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
    - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
    - Full lobbying policy found on Collaboration site (Structure and Functions).

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

- Doctor Silva shared the following procedural issues for RUC members:
    - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
    - RUC members or alternates sitting at the table may not present or debate for their society.
    - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.

- Doctor Silvia conveyed the following procedural guidelines related to Voting:
    - Work RVU = 2/3 vote
    - Motions = Majority vote
    - RUC members will vote on all tabs using the voting repository with links provided via email.
    - You will need to have access to a computer or smart phone to submit your vote.
    - If you are unable to vote during the meeting due to technical difficulties, please contact Gregory Craig.
    - RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
    - We vote on every work RVU, including facilitation reports.
    - If members are going to abstain from voting please notify AMA staff so we may account for all 29 votes.

- 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.
  - Facilitation Committee meetings are set up for 4pm-6pm via Microsoft Teams if necessary.

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

III. Director's Report

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

- Ms. Smith conveyed the following information regarding the RUC Database application update:
  - The RUC database has been updated and is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets.
  - Download offline version, you will be prompted whenever there is an update available.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - Changes for the 2021 v2 RUC Database application include:
    - 2019 Billed Together and Units of Service Data
    - 2019 Medicare Beneficiary Summary Data
    - 2019 Top ICD-10 Diagnoses Data
    - 2019 Typically Emergent Data
  - The Billed Together tab is new and should be helpful for participants while reviewing codes.

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

- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2023 Cycle:
    - RUC Recommendation due dates:
        - September 9, 2021 (for October RUC meeting)
        - December 14, 2021 (for January RUC meeting)
        - April 5, 2022 (for April RUC meeting)
    - RUC Meetings:
        - October 6-9, 2021 (location: Chicago, Illinois)
        - Jan 12-15, 2022 (location: San Diego, California)
        - April 27-30, 2022 (location: Chicago, Illinois)

IV. Approval of Minutes from January 2021 RUC Meeting

The RUC approved the January 2021 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 the COVID-19 pandemic:

- Panel meeting activity in response to COVID-19 pandemic:
    - The panel has continued to create COVID-19 vaccine codes.
    - 14 total CPT codes creased for COVID-19 vaccine product and administration codes
        - 5 product codes (Pfizer, Moderna, Janssen, AstraZeneca, Novavax)
        - 9 vaccine administration codes (per dose)
    - The administration codes have been structured to accommodate booster doses if, and when, they come to market.
    - Note that the Novavax codes are being held for a limited time to finalize the NDC numbers with the CDC
        - Initial anticipated publication was April 16
        - Should not affect any RUC review
    - The Panel thanks the RUC for their work on immediately reviewing the physician work and practice expense for these new codes.

- May 2021 CPT Editorial Panel meeting:
    - The next virtual panel meeting is May 6-8, 2021.
    - The next code change application submission deadline is June 30, 2021 for the September 30-October 2 Panel meeting.
    - For the May 2021 Panel meeting there are 53 agenda items. The notable items include:
        - 4 digital medicine related CCA's
        - 3 CCA's requesting movement from Category III to Category I
        - Consideration of 11 Physical Medicine and Rehabilitation services to Appendix P (CPT Codes that may be used for synchronous Telemedicine Services)
        - Deletion of Appendix C – Clinical Examples
            - E/M Workgroup determined these clinical examples for E/M services were not necessary with the revisions approved for 2023.
        - Code set maintenance – 9 low utilization services were confirmed from February Advisory Committee review to be presented for deletion by the Panel at the May meeting.

- RUC Referral – Tab 41 Somatic Nerve Injection Code Revisions. This includes adding ultrasound guidance to the somatic nerve injection codes.
- Panel Executive Committee Review
    - Tab 16 (CPT February 2021 meeting) – Endoscopic Bariatric Device Procedures
    - Specialty society noted missing exclusionary parenthetical for code 43291.

VI. Washington Update (Informational)

Jennifer McLaughlin, JD, Assistant Director of Federal Affairs, AMA, provided the Washington report focusing on advocacy to support physician practices and their patients during the COVID-19 public health emergency.

- Sequestration Cuts Averted:
    - Congress delayed 2% across-the-board Medicare sequester cuts through December 31.
    - Physician practices are already financially distressed, and Congress recognized that these cuts would be devastating during the pandemic.

- COVID-19 Immunization Administration:
    - CMS nearly doubled Medicare payment for COVID 19 vaccine administration to $40 per dose starting March 15.
        - RUC and AMA advocated for increased payment to safely and appropriately administer the vaccines during the pandemic.
            - Increased costs for infection control and safety protocols are described by the CPT Editorial Panel with the new CPT code 99072 and are now bundled into the COVID 19 immunization administration payments.
        - No out-of-pocket costs for patients
            - HHS OIG receiving reports of patients being inappropriately charged.

- Medicare Advance Payments:
    - COVID 19 Accelerated and Advance Payment repayment began on March 30
        - AMA strongly advocated for improved repayment terms, which Congress and CMS adopted in 2020:
            - Repayment begins one year after the Medicare advance payment was received, rather than 120 days under the original terms.
            - The per claim recoupment amount was reduced from 100% to 25% for the first 11 months, and then 50% for an additional 6 months.
            - If a balance remains after the recoupment time frame, the MAC will issue a demand letter and the balance is subject to an interest rate of 4%, down from the original rate of 10.25%.
            - Practices may repay the advance payment in full at any time by contacting their MAC.
        - AMA is interested in feedback about physicians' experiences with repayment and whether they are able to check the balance or request a payment plan due to hardship.
    - AMA COVID-19 financial relief resources

- President Biden Administration:
  - AMA has maintained dialogue with the new Administration, particularly focused on COVID-19 priorities.
  - HHS Appointments
    - Xavier Becerra HHS Secretary; many senior HHS staff named
      - Rochelle Walensky, CDC Director
      - Vivek Murthy, Surgeon General
      - Rachel Levine, Assistant Secretary for Health
      - Chiquita Brooks LaSure, CMS Administrator nominee

- Administration Priorities:
  - COVID-19 Public Health Emergency (PHE) expected to be extended through end of the year
    - Multiple executive orders on COVID; National Strategy document
    - COVID-19 Response Team at White House
    - AMA COVID-19 What Physicians Need to Know Webinar Series
    - April 13 AMA and FDA discussion on J&J COVID 19 vaccine pause
  - Medicare Part D – Biden Administration rescinded a proposal from the previous administration that would have allowed Part D plans to limit coverage of some drugs in six protected classes, including cancer drugs.
  - Strengthen the ACA – Biden Administration extended the special enrollment period through August 15th, rolling back Medicaid work requirements.

- Information Blocking Rules:
  - Office of the National Coordinator (ONC) Information Blocking rules effective as of April 5
    - Information blocking interferes with or imposes delays in the access, exchange and use of patients' electronic health information.
    - AMA policy supports legislative and regulatory prohibitions on info blocking and is a longstanding advocate of eliminating major contributors to info blocking on EHR vendors and for patient access.
    - The AMA is also engaged with the Administration to address concerns that HHS' rule forces physicians to release office notes and test results prior to physicians reviewing the information with the patient.
    - AMA information blocking resources; CME resource launches this week.

- Merit-based Incentive Payment System (MIPS)
  - New study – Physician Practice Leaders' Perception of MIPS:
    - MIPS is understood as a continuation of previous value-based payment programs and a precursor to future programs.
    - Measures are more relevant to primary care practices than other specialties.
    - Leaders are conflicted on whether the program improves patient care.
    - MIPS creates a substantial administrative burden.
    - Incentives are small relative to the effort needed to participate.
  - AMA is working with specialties to identify a path forward on MIPS and APMs.

- AMA Advocacy on Telehealth Beyond COVID-19
  - HHS announcement that the PHE will likely be extended through end of 2021 means waivers of geographic + originating site policies that had restricted Medicare telehealth services will continue.

  - AMA is seeking permanent lifting of these restrictions by:
    - Supporting Telehealth Modernization Act (S.368/H.R 1332) that repeals geographic restriction and adds as new originating site any site where the patient is located.
    - Reviewing revised draft of CONNECT for Health Act. The AMA supported CONNECT for Health Act in the 116th Congress.
  - Important for CMS to continue paying for audio only visit codes.
  - Need to extend coverage of codes on Medicare Telehealth List beyond PHE to allow development of evidence on their effective use outside pandemic.
  - Conducting research to see how telehealth contributes to better health, move toward digitally enabled hybrid models combining in person + telehealth services.

- Ms. McLaughlin answered questions from the attendees:
  - A RUC member inquired about whether the AMA was considering finding sponsors for legislation regarding code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* at the federal level. Ms. McLaughlin responded that there are conversations with the Administration and with CMS about the importance of 99072, but she is unaware of anything on the legislative side.
  - A RUC member raised a point about the importance and concern around information blocking.
  - A RUC member inquired about last year's 2.2% increase and what it costs to participate successfully in MIPS, in particular for those high performing practices, and deliver on that increase. Ms. McLaughlin responded that the study, regarding the 2.2% increase, is a two-part study and the second part has not been published but looked at exactly the information that the RUC member is inquiring about.
  - A RUC member asked if the 2% sequester will take effect on January 1, 2022 and inquired about any other potential cuts that will take effect in 2022. Ms. McLaughlin stated that yes, there are other cuts that could potentially go into effect in addition to the 2% sequester and they are on the AMA's radar. There could be an additional layer of the sequester due to the passage of the recent American Rescue Plan Act which would trigger an additional cut of -4%.
  - A RUC member inquired about CMS development of episode definitions or "triggers" that would align with specific quality metrics that would be used to satisfy MIPS and if Ms. McLaughlin could provide clarification on that effort. Ms. McLaughlin explained that CMS is trying to respond to these challenges as criticism of MIPS that have been present for a long time, especially the four silos: quality, cost, health IT, clinical improvement activities. The program is not geared towards the way physicians practice and the AMA is working on this harmonization of the four categories with CMS. We expect to see some changes in the Proposed Rule within the MIPS value pathways that CMS has worked on with specialties.

Medicare Physician Spending and Utilization Growth Update

Kurt Gillis, PhD, Principal Economist, AMA, provided an overview of changes in Medicare physician spending during the COVID-19 Pandemic.

- Overview: Medicare Physician Spending During the Pandemic
    - Focus is on Medicare Physician Fee Schedule (MPFS) services
    - Take a broader look at spending and consider the timing of impacts
    - Objectives:
        - Identify providers and settings that were most affected
        - Examine the shift to telehealth

- Data and Methods:
    - Using claims for a 5% sample of Medicare beneficiaries.
    - Files are available quarterly from CMS.
    - Estimate impacts through third quarter of 2020 (January - September).
    - Previous AMA report estimated impacts through second quarter.
    - Impacts are measured by comparing 2020 spending to the pre-pandemic trend.
    - Total are extrapolated to the full fee-for-service population.

- Overall MPFS Spending January-September 2020. *Please see attached presentation for graphics.*
    - MPFS spending dropped sharply in mid-March 2020.
    - Reached a low of $845 million in allowed charges for the week ending April 10, 2020 (57% below expected spending of $1.96 billion for that week).
    - Spending recovered but was still down 8% at the end of the third quarter.

- MPFS Spending by Type of Service January-September 2020. *Please see attached presentation for graphics.*
    - Four broad categories were included in the analyses: E/M, imaging, procedures, and tests.
    - E/M stands out as the drop is not as significant as the other services spending. E/M dropped to about 50% of expected spending by the end of March when it then flattened out and recovered.
    - Imaging procedures and tests spending continue to go down until mid-April to anywhere between 65-70% below expected spending but leveled out by the third quarter.

- MPFS Spending by Place of Service January-September 2020. *Please see attached presentation for graphics.*
    - Top settings for Medicare physician services included for analyses: skilled nursing facility, inpatient hospital, emergency room-hospital, office, outpatient hospital, and ambulatory surgery center.
    - Skilled nursing facilities had the smallest reduction at ~20% but did not fully recover by the third quarter as reductions were still present.
    - In-patient hospital declined by as much as 40% during the height of the pandemic back in April. However, by the end of the third quarter it was only down about 2%.
    - Office spending was down over 60% in Mid-April before recovering.
    - The ASC setting presented as the outlier which was down 90% in the month of April before recovering.

- The Cumulative Reduction in MPFS Spending for January-September 2020 was $11.5 Billion
    - Cumulative reduction:
        - Expected spending January-September 2020 = $72.6 billion
        - Minus actual spending = 61.0
        - = Cumulative Impact of 11.5 billion
    - The $11.5 billion cumulative reduction amounts to a 16% reduction in MPFS spending for the first nine months of 2020.

  - (Note: spending is allowed charge includes both what Medicare pays and beneficiary deductible, coinsurance.)

- Cumulative Reduction by Specialty. *Please see attached presentation for graphics.*
  - There is a large range in impacts among the top specialties:
    - The low end included nephrology down 4%, radiation oncology down 7%, and the high end included ophthalmology down 22%. Physical therapy down 31%.
    - Overall reduction was ~16%.
    - Internal medicine was down 11% and family medicine was down 13%.

- Cumulative Reduction by State. *Please see attached presentation for graphics.*
  - There is not as much of a range at the state level:
    - The biggest drops are apparent in the Northwest and the upper Midwest. The smaller reductions were in the south and the Southwest.
    - Spending in every state went down.

- Telehealth Spending
  - Telehealth is defined as:
    - CPT/HCPCS codes on CMS' telehealth list (including those added during the pandemic) AND
    - Billed with a telehealth modifier or place of service.
  - Examine spending overall and by service category.

- Telehealth Spending as a Share of MPFS Total. *Please see attached presentation for graphics.*
  - There are three distinct periods represented: before the pandemic, initiation of the pandemic, and the continuation of the pandemic.
  - Prior to the pandemic there is almost no use of Telehealth in Medicare at 0.1% of total spending.
  - In April spending was at ~16% of total fee schedule spending.
  - By the end of the second quarter, it was ~6% of spending and by the end of the third quarter it was just under 5% spending.
  - There was a gradual downward trend in the use of telehealth in the second and third quarters of 2020, but it is still greater than it was prior to the pandemic.

- Nearly Half of the 3.0 Billion in Telehealth Spending January-September 2020 was for Established Patient Office Visits. *Please see attached presentation for graphics.*
  - Office visits – established patient: 49%
  - Telephone calls: 19%
  - Mental health and behavioral health services: 16%
  - Nursing facility visits: 4%
  - Office visits – new patient: 4%
  - All other: 9%

- Share of Frequency Provided as Telehealth. *Please see attached presentation for graphics.*
  - There are three distinct periods represented: before the pandemic, initiation of the pandemic, and the continuation of the pandemic.
  - During the second and third quarters, over half of mental health and behavioral health services were provided as telehealth.
  - About a quarter of established patient office visits were provided as telehealth from March 16 to June 30 and then dropped to about one in eight visits in the third quarter.

- Number of Established Patient Office Visits Per Week. *Please see attached presentation for graphics.*
    - A breakdown between in-person and telehealth visits for established patient office visits:
        - Before the pandemic, there were over ~4 million visits per week and that dropped rapidly in March. By mid-April, in-person visits dropped to ~1 million per week. At that point in-person and telehealth numbers were very close but did not surpass one another.
        - In-person visits recovered by the third quarter of 2020 to ~4 million total visits per week and ~10% of those are telehealth.

- In Summary:
    - Medicare physician spending was down as much as 57% in April 2020 and was still 8% below expected spending at the end of September.
    - Substantial variation in impacts by type and place of service, specialty, and state.
    - Rapid adoption of telehealth for E/M and Mental Health.
    - An estimated $11.5 billion (16%) cumulative reduction in spending through the third quarter of 2020.

- Looking Ahead:
    - What impacts will these changes in utilization have on the health of Medicare beneficiaries?
    - When will spending/utilization reach pre pandemic levels?
    - Will pent up demand result in a post PHE surge in utilization?

- Dr. Gillis answered questions from the attendees:
    - A RUC member inquired about the $11.5 billion in savings and what will happen with those savings. Dr. Gillis explained that in the current system it will go toward reducing the deficit. However, there could be a bounce back with increased spending due to delayed care, but we have yet to see that in the third quarter.
    - A RUC member asked if the cost outline included the cost of care for COVID-19 patients. Dr. Gillis stated that they were included and explained that it is reflective of fee-for-service spending and claims are being submitted for COVID patients, so it is being counted in the cost outline.
    - A RUC member inquired about whether data has been analyzed on the correlation between the places that were hardest hit by COVID-19 and if that changed the percentage of telemedicine compared to other spending. Dr. Gillis responded that he has not explored this but that it would be interesting to break that comparison down by geographical level.
    - A RUC member asked about the pie chart related to telehealth spending and how the items within mental health and behavioral health services were divided up as it seems to overlap with the new patients, existing patients, and telephone call pieces of the chart. He also inquired about how substance abuse fits into this graphic. Dr. Gillis and Ms. Smith explained that the categories are based on CPT codes instead of diagnosis codes which would have included some of those phone calls related to behavior health.
    - A RUC member inquired about the AMA's tracking of primary care practice mergers or consolidations during the last year. Dr. Gillis explained that the AMA has a survey every two years and 2020 happened to be a survey year. In this survey, the AMA asks about practice arrangements and practice size. Those results are posted to the AMA website, available here.

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

Gift Tee, MPH, Director, Division of Practitioner Services, provided the report of the Centers for Medicare and Medicaid Services (CMS) with an overview of the 2021 Physician Fee Schedule (PFS) Final Rule.

- Changes to the Physician Fee Schedule (PFS) for CY 2021:
  - On December 2, 2020, CMS issued a Final Rule that included policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2021. Some of these changes included:
    - CY 2021 PFS Ratesetting and Conversion Factor
    - Medicare Telehealth
    - Remote Physiologic Monitoring
    - Direct Supervision Definition
    - Scope of Practice and Other Related Issues
    - Teaching Physicians and Residents
    - Payment for Evaluation and Management (E/M) and Analogous Visits
    - Opioid Use Disorder/Substance Use Disorder Provisions
    - Changes Enacted by the Consolidated Appropriations Act 2021

- Consolidated Appropriations Act, 2021:
  - Following the release of the CY 2021 PFS Final Rule, the Consolidated Appropriations Act, 2021, was enacted on December 27, 2020. The law included several provisions that resulted in increases in PFS payment amounts effective January 1, 2021, including:
    - Provision of a 3.75% increase in MPFS payments for CY 2021
    - Suspension of the 2% payment adjustment (sequestration) through March 31, 2021
    - Reinstatement of the 1.0 floor on the work Geographic Practice Cost Index (GPCI) through CY 2023
    - Delayed implementation of the inherent complexity add-on code for evaluation and management services (G2211) until CY 2024
  - CMS recalculated the MPFS payment rates and conversion factor to reflect these changes. The revised payment rates are available in the Downloads section of the CY 2021 Physician Fee Schedule final rule (CMS-1734-F) webpage.

- Correction Notices to the Physician Fee Schedule (PFS) for CY 2021:
  - On January 19 and March 18, 2021, CMS released correction notices to the CY 2021 PFS Final Rule which addressed clarifications and proposals related to digitally stored data services/remote physiologic monitoring/treatment management services, responses to public comments and corrected addenda errors. These corrections can be accessed and viewed at the links below:
    - January 19, 2021
    - March 18, 2021
    - CMS also made updates to the Medicare telehealth list of services. These updates can be accessed and viewed here.

- CY 2022 Physician Fee Schedule (PFS) Rulemaking Updates & Other Updates:
  - CMS is actively working on CY 2022 PFS rulemaking
  - Other updates:
    - Secretary of the Department of Health and Human Services (HHS)
    - Awaiting other HHS and CMS Leadership confirmations
    - Public Health Emergency extended, effective April 21, 2021

- Mr. Tee addressed questions from the attendees:
  - A RUC member asked what the RUC might expect for the 2022 conversion factor. Mr. Tee stated that CMS is considering the RUC 2022 recommendations and other policies that intersect and influence the conversion factor.
  - A RUC member inquired about changes to E/M requirements and documentation and if those changes are applicable for other E/M families that are still under review. Mr. Tee responded that the documentation requirements that changed were specific to the office outpatient E/Ms. There will be consideration for what document requirements apply when recommendations are being reviewed.
  - A RUC member inquired about the direction of telehealth and any direction that may be helpful for the CPT and RUC. Mr. Tee stated that the PHE has provided tremendous experience in the Telehealth space and new CMS leadership could shape the direction of Telehealth further.
  - A RUC member raised the point that many medical professionals' work includes supervising residents and students, and it is important to keep in mind how the rules could affect the training of the next generation of learners. Mr. Tee acknowledged this point.

VIII. Contractor Medical Director Update (Informational)

Doctor Lawrence, Medicare Contractor Medical Director (CMD), provided the CMD update covering the MAC Local Coverage Determination (LCD) Process.

- An update on what is new and useful links:
  - Several of the MAC's have added new CMDs or DMDs in the past few months
  - Upcoming Open Meetings
  - Two new Multi-jurisdictional Workgroups
  - Update on the third level of appeal (ALJ) backlog
  - Artificial Intelligence
  - MolDX/PLA codes
  - Useful links:
    - CMS Listing of MAC CMD Directory Listing
    - CMS Landing Page for Upcoming CACs and Open Meetings

- Multi-jurisdictional Workgroups:
  - Artificial Intelligence (AI)
  - Pricing

- Administrative Law Judge (ALJ) backlog:
  - HHS Medicare Appeals Backlog was reduced by 43% as of the second quarter of the calendar year 2020. At the end of 2020 it has been reduced by 53%.
  - This puts it ahead of schedule in clearing the backlog
  - This has been accomplished by multiple measures including:

        - Settlements
        - On the record decisions from Attorney adjudicators
        - DME Demonstration
        - Adding new ALJ's to the process
    - The ALJ is on target to reduce the backlog by greater than 75% by the end of 2021, so this puts it ahead of schedule

- Artificial Intelligence vs Algorithms:
    - Many companies are developing new technologies or software that is called "AI"
    - There are a number of technologies out there that employ algorithms to analyze data

- Artificial Intelligence:
    - One definition is the simulation of human intelligence by machines (usually computers or software) that are programmed to "think" like a human being.
    - Another is machines that respond to stimulation consistent with traditional human responses (i.e., they are given the human capacity for contemplation, judgement or intuition)
    - Put more simply, a machine or software that is able to recognize patterns (input), analyze (them/it), and draw conclusions
    - Put simplest "machine learning"

- Artificial Intelligence Workgroup & Questions to Consider:
    - In our work group we look at the following questions:
        - Does it have a benefit category?
        - Does it add anything to the present standard of care?
        - Is it just another way to perform the same procedure and not necessarily in a better, more efficient, or safer way?
    - The MAC's have formed an AI workgroup to assist with approaching the coverage of the technologies in a consistent manner
    - The AI workgroup is in the very early stages

- MolDX/Proprietary Lab Analysis:
    - New lab tests are being developed all the time.
    - Some test for so many different antigens, viruses, bacteria or genes, it is difficult to determine how the information is used for clinical decision making.
    - Some identify genes that are present in various conditions, but this identification does not result in a change in medical management.
    - Analyzing the results:
        - Is it a screening test?
        - Will it change or inform the medical management of the patient?
        - Is it the most specific test available for the clinical concern?

- Doctor Lawrence addressed questions from the attendees:
    - A RUC member asked if there are any plans to expand the multi-jurisdictional approach to creating the LCDs and Local Coverage Articles (LCAs). Doctor Lawrence responded that yes, it will occur when possible but to remember that each jurisdiction has its own individual needs and when new situations/technology arise then more work groups will be created based on need.

IX. Relative Value Recommendations for *CPT 2022*

Arthrodesis Decompression (Tab 4)
Presenters: William Creevy, MD (AAOS), Hussein Elkousky, MD (AAOS), Morgan Lorio MD (ISSAS), John Ratliff, MD (AANS), Clemens Schirmer, MD (CNS) and Karin Swartz, MD (NASS)

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A CPT coding change application (CCA) was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for CPT codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 6305) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, and revised definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment." In January 2021, the specialty societies surveyed the two new add-on codes and indicated that the revisions to existing codes were editorial precluding survey. The RUC disagreed and recommended that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 and 6305) be surveyed together for review at the April 2021 RUC meeting and interim values were established for CPT codes 63052 and 6305 until these two new codes could be reviewed again with the entire family in April.

22630 ***Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that maintaining the current work RVU of 22.09, which falls well below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components as supported by the survey: 40 minutes pre-service evaluation, 20 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 150 minutes intra-service time, and 30 minutes immediate post-service time, 1-99238 discharge visit, 1-99231 and 2-99232 post-operative visits and 2-99213 and 1-99214 office visits, 479 minutes total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as not to exceed survey median data. The positioning time was increased from the pre-time package to account for the additional work related to prone positioning.

The RUC noted that the total recommended time of 479 minutes is nearly identical to the total time of both the survey and the current code (487 minutes) which was initially valued in 1995. The post-operative visits have decreased by one, but the level of the visits has changed, practically resulting in a net change of zero in overall physician time despite the decrease of one visit. The RUC discussed the significant decrease in intra-service time of 30 minutes and considered crosswalk code alternatives; however, none of the crosswalk code options were deemed clinically comparable or sufficiently matched to the difficulty of the procedure. The change in time for the survey code, since it was valued in 1995, is attributed intra-operatively to the use of more effective drills, better X-rays, and several steps that streamline the procedure and make it more efficient. However, the RUC noted that while the procedure may be more efficient, it is not safer or less difficult. The elements that remain are intense, such that the risk of the procedure, remains the same as it was originally; therefore, the RUC agreed that the current value should be maintained.

To justify the current work RVU of 22.09, the RUC compared the survey code to the top key reference service codes 22533 *Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar* (work RVU = 24.79, 180 minutes intra-service time and 549 minutes total time) and 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time and 482 minutes total time) and noted that the majority of respondents who chose 22533 as a key reference service indicated that the intensity/complexity of 22630 is similar to or somewhat more than 22533. Also, the respondents who chose 22612 as a key reference service indicated the intensity/complexity of 22630 is more than 22612.

The RUC also compared CPT code 22630 to MPC codes 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time and 404 minutes total time) and 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* (work RVU = 23.53, 150 minutes intra-service time and 502 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation. For additional support, the RUC noted that the survey code is further bracketed by comparator codes 38720 *Cervical lymphadenectomy (complete)* (work RVU = 21.95, 150 minutes intra-service time and 482 minutes total time) and 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59, 150 minutes intra-service time and 480 minutes total time). The RUC concluded that the value of CPT code 22630 should be maintained at 22.09 work RVUs, which is below the 25th percentile of the survey. **The RUC recommends a work RVU of 22.09 for CPT code 22630.**

22632 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)*

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that maintaining the current work RVU of 5.22, which falls well below the survey 25th percentile, appropriately accounts for the physician work involved in this add-on service. The RUC recommends 60 minutes of intra-service time and noted that the intraoperative time has not changed since the code was initially valued in 1995. At that time, the value of this code was calculated based on 25% of the base code.

The specialties noted that a comparison to the key reference service codes 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service time and 50 minutes total time) might support a higher work RVU, however, there was no compelling evidence that the work had changed. The RUC agreed that work had not changed.

The RUC also compared CPT code 22632 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the comparator code has less intra-service and total time and is appropriately valued lower than the survey code. The specialties noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA) while, in

comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same time and similar intensity: 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and 22854 *Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)* (work RVU = 5.50, 60 minutes intra-service and total time). The RUC concluded that the value of CPT code 22632 should be maintained at 5.22 work RVUs which is below the 25th percentile of the survey. **The RUC recommends a work RVU of 5.22 for CPT code 22632.**

22633 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and concurred that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that changes in intra-service and total time for the procedure warranted a direct work RVU crosswalk to MPC code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU= 26.80, 180 minutes intra-service and 442 minutes total time) which falls below the survey 25th percentile and has identical intra-service time that appropriately accounts for the total physician work involved in this service.

The RUC recommends the following physician time components as supported by the survey: 40 minutes pre-service evaluation, 20 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 180 minutes intra-service time, and 30 minutes immediate post-service time, 1-99238 discharge visit, 1-99231 and 2-99232 post-operative visits and 2-99213 and 1-99214 office visits, 509 minutes total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as not to exceed survey median data. The positioning time was increased from the pre-time package to account for the additional work related to prone positioning. The RUC used a crosswalk due to the changes in visits that caused a decrease in total time, primarily due to a change in inpatient care. Previously, there were two level-3 hospital visits and one level-2 hospital visit, this has been decreased to two level-2 and one level-1 inpatient visit along with a discharge day visit causing a substantial decrease in total time for the procedure, greater than the decrease in intra-service time; thus, a crosswalk was selected rather than recommending maintaining current value. The RUC discussed the recommended crosswalk code 55866 and noted that it is recently reviewed and performed 20,000/year and places the intraoperative intensity appropriately within this family of codes.

To justify the crosswalk value of 26.80 work RVUs, the RUC compared the survey code to the top key reference service code 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time and 482 minutes total time) and 2nd key reference code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar* (work RVU = 27.13, 180 minutes intra-service time and

550 minutes total time) and noted that the physician work and total time of the survey code is appropriately bracketed between the two reference services using magnitude estimation.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same intraoperative time and similar intensity: 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh (complete)* (work RVU = 26.60, 180 minutes intra-service time and 424 minutes total time). The RUC concluded that, given changes in intra-service and total time for the procedure, CPT code 22633 should be valued based on a direct work RVU crosswalk to CPT code 55866 which falls below the survey 25th percentile and preserves rank order within the family. **The RUC recommends a work RVU of 26.80 for CPT code 22633.**

22634 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 7.96 appropriately accounts for the physician work involved in this add-on service and is less than the current value. The RUC noted that the current value for 22634 is based on a calculation in 2011 that estimated the new add-on code was 70% of the survey 25th percentile work RVU. Although the current survey median work RVU would suggest an increase is warranted, the specialty did not present compelling evidence for an increase and the RUC recommends a decrease in the work RVU to account for the five minute decrease in median intra-service time. The RUC recommends 65 minutes of intra-service time as supported by the survey. The RUC noted that this service is more difficult and complex than CPT code 22632 due to the more complex patient undergoing this procedure and considerable additional steps that are not included in 22630 and 22632.

To justify a work RVU of 7.96, the RUC compared the survey code to the top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that the survey code has greater intra-service and total time and involves more physician work than the reference service. It was also rated as more intense/complex overall than the key reference service by 88% of survey respondents who selected the KRS. The RUC also compared CPT code 22634 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code has much less intra-service and total time and is appropriately valued lower than the survey code.

For additional support, the RUC noted that the survey code is bracketed by comparator codes 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 7.00, 60 minutes intra-service and total time) and 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)* (work RVU = 8.00, 60 minutes intra-service and total time). The RUC concluded that CPT code 22634 should be

valued at the 25th percentile work RVU as supported by the survey and comparator codes. **The RUC recommends a work RVU of 7.96 for CPT code 22634.**

63052 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 5.70 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 45 minutes intra-service time and noted that the time has increased by five minutes compared to the previous survey and that the recommendation is slightly higher than the interim recommendation. This code was initially surveyed in January of 2021. At that time, the RUC concluded that the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. The RUC was concerned that without the base codes and add-on codes being surveyed together, that the survey for the add-on codes may have included work from the primary codes. For this reason, an interim value was assigned with guidance to the specialties to perform a new survey to include the add-on codes and the base codes. The current survey included all six codes on one survey instrument. Additionally, the overall experience of the survey respondents is greater for the new survey of six codes when compared to the prior survey of only the new add-on codes. The RUC determined that the value of 5.70 is more accurate as it is based on the survey of the entire code family and further noted that compelling evidence is not necessary for increases over interim values since interim values are, by definition, temporary. The RUC also noted that the time included in this add-on service is essentially all high-risk. The lower intensity surgical exposure activities have already been completed with the base code, so the physician work of 63052 involves is the actual higher intensity decompression as clarified by CPT.

To justify a work RVU of 5.70, the RUC compared the survey code to the top key reference service code 22840 *Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)* (work RVU = 12.52, 60 minutes intra-service and total time) and noted that the reference code has both more physician work and intra-service time and is therefore valued higher.

The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work, time, and intensity of 63052 is greater than 34812.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same intraoperative time and similar intensity: 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service time and 50 minutes total time) and code 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare*

interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) (work RVU = 5.52, 45 minutes intra-service and total time). The RUC concluded that CPT code 63052 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes using magnitude estimation. **The RUC recommends a work RVU of 5.70 for CPT code 63052.**

6305 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic and spine surgeons and determined that the survey 25th percentile work RVU of 5.00 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 40 minutes intra-service time and noted that the time has increased by ten minutes compared to the previous survey. This code was initially surveyed in January of 2021. At that time, the RUC concluded that the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. For this reason, an interim value was assigned with guidance to the specialties to perform a new survey to include the add-on codes and the base codes. The new survey, which included all six codes, elicited a time that is only five minutes less than the work related to 63052 and is believed to be a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and of an additional segment. The RUC determined that the new value is more accurate as it is based on the survey of the entire code family and further noted that compelling evidence is not necessary for increases over interim values since interim values are, by definition, temporary.

To justify a work RVU of 5.00, the RUC compared the survey code to the top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that the codes have the same intra-service time, but the reference code is more intense and is appropriately valued higher than the survey code using magnitude estimate. The RUC also compared the survey code to the second key reference service code 22840 *Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)* (work RVU = 12.52, 60 minutes intra-service and total time) and noted that this reference code has more physician work and intra-service time and is therefore valued higher than the survey code.

The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time for 6305 includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work and intensity of 6305 is appropriately greater than 34812.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the similar intraoperative time and similar intensity: 44128 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary*

procedure) (work RVU = 4.44, 40 minutes intra-service and total time) and 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes intra-service and total time). The RUC concluded that CPT code 6305 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes using magnitude estimation. **The RUC recommends a work RVU of 5.00 for CPT code 6305.**

Practice Expense
The Practice Expense Subcommittee removed the EQ168 *light, exam* for CPT codes 22630 and 22633. No direct practice expense inputs were recommended for the facility-only add-on codes 22632, 22634, 63052 and 63053. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Drug Induced Sleep Endoscopy (DISE) (Tab 5)
Presenters: R. Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)

In October 2020, the CPT Editorial Panel created a new code to report drug induced sleep endoscopy (DISE) flexible, diagnostic. At the January 2021 RUC Meeting, the RUC requested that this service be resurveyed for the April 2021 RUC Meeting using a standard 000-day survey template.

42975 ***Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic***
The RUC reviewed the survey results from 89 otolaryngologists for CPT code 42975 and determined that the survey 25th percentile work RVU of 1.95 appropriately accounts for the physician work required to perform this service. The RUC recommends 18 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 15 minutes of intra-service time, and 10 minutes of immediate post-service time, and 50 minutes of total time for CPT code 42975. The specialty society noted that this procedure involves endoscopic evaluation of the upper airway for sleep apnea from the tip of the nose down to the larynx to identify the type and location of the airway obstruction and to determine specific maneuvers that would alleviate the obstruction and the effect that interventions have on the collapse. The specialty society noted that the sedation involved in this procedure mimics the conditions of sleep and that the accompanying muscle and tissue collapse of the airway make endoscopic visualization more difficult.

The RUC compared CPT code 42975 to the top key reference service CPT code 31579 *Laryngoscopy, flexible or rigid telescopic, with stroboscopy* (work RVU = 1.88, 10 minutes intra-service and 34 minutes of total time) and noted that 80 percent of survey respondents determined 42975 to be more complex than key reference service 31579 and that the recommended intra-service time and total time for 42975 support a work RVU of 1.95 in appropriate rank order compared with 31579.

The RUC also compared the survey code with CPT code 62321 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.95, 15 minutes of intra-service and 45 minutes of total time), MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 15 minutes of intra-service and 49 minutes of total time), and CPT code 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU = 1.93, 15 minutes of intra-service and 48 minutes of total

time) and noted that the recommended total time and work RVU fits appropriately within this range of codes. **The RUC recommends a work RVU of 1.95 for CPT code 42975.**

Practice Expense
The Practice Expense Subcommittee affirmed the practice expense inputs from the January 2021 RUC meeting. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Transcutaneous Passive Implant-Temporal Bone (Tab 6)
Presenters: R. Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)

In October 2020, the CPT Editorial Panel revised two codes to replace "temporal bone" with "skull" and delete "or transcutaneous" and "cochlear stimulator: without mastoidectomy" from the descriptors. The Panel also replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

At the January 2021 RUC Meeting, the RUC reviewed these services and determined that they need to be resurveyed for the April 2021 RUC Meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically the lower end of the RVU spectrum. The specialty society submitted a letter to the RUC requesting that this service be referred to CPT in May 2021 to clarify the percutaneous implant removal by describing the procedure as removal of the entire implant, add a parenthetical to report removal of the abutment alone to be an included component of the evaluation and management visit and to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm2 surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm2 surface area of cranium beyond its outer cortex. The specialty society will survey these codes for the October 2021 RUC Meeting.

The RUC recommends affirming the January 2021 interim RUC recommendations for work and practice expense inputs for CPT codes 69714, 69716, 69717, 69719, 69726, and 69727 and resurveying these codes for the October 2021 RUC meeting following revisions at the May 2021 CPT Editorial Panel meeting.

Cardiac Ablation (Tab 7)
Presenters: Christopher Liu, MD (HRS), Mark Schoenfeld MD (HRS), David Slotwiner, MD (HRS), Edward Tuohy, MD (ACC), Thad Waites (ACC) and Richard Wright, MD (ACC)

The RUC identified CPT code 93656 with Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019e. In January 2020, the RUC recommended to refer this issue to the CPT Editorial Panel in May 2020 for revision and bundling. Technology and clinical practice have changed since these codes were developed in 2011. Based on the billed together data for these and related codes, the specialty societies recommended referral to CPT to update code descriptors and likely bundle services now commonly performed together, such as 3D mapping. In October 2020, the CPT Editorial Panel revised one code (93653) to bundle with 3D mapping and to include "induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus," and another (93656) to add 3D mapping and "left atrial pacing and recording from coronary sinus or left atrium" and "intracardiac echocardiography including imaging supervision and interpretation" to their descriptors.

The surveying specialties had submitted a letter to the CPT Editorial Panel in December 2020 requesting that the coding changes for these services to be rescinded for CPT 2022 due to the specialty's concern that the RUC survey respondents may have been confused about the coding changes. In February 2021, the CPT Editorial Panel Executive Committee did not rescind their changes, which were among the coding changes for CPT 2022. Since the request to rescind the changes was not considered by CPT until after the January 2021 RUC meeting and January 2021 was the last RUC meeting of the CPT 2022 cycle, the RUC had recommended for these services to be valued as interim for CPT 2022 and that the codes would be resurveyed and reviewed at the April 2021 RUC meeting.

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; 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***

The RUC reviewed the survey results from 62 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 15.00 for CPT code 93653. The RUC recommends 31 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time and 30 minutes of immediate post-service time. The RUC noted that CPT code 93653 was revised to now bundle the physician work of CPT codes 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* and 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)*, which previously were separately reported add-on services.

The specialties noted that the actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much greater feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. For instance, the ablation treatment is much more intense in terms of risk of heart block and esophageal injury. Furthermore, while the physician is obtaining many more data points to create the 3-dimensional map, the physician still needs to make sure every one of those points are accurate as review of points is not automated.

The specialties noted that 93653 is typically the most intense service to perform among the three base codes in this family (93653, 93654 and 93656). CPT code 93653 is typically performed on a young patient who does not have other conditions and the ablation site occurs very close to the patient's innate conduction system. There is an approximately 0.5 percent to 1 percent risk of causing heart block requiring a permanent pacemaker. The time when the physician is applying radiofrequency energy is extraordinarily intense as opposed to the other two ablation services, 93654 and 93656,

which are longer procedures on generally sicker patients and the intensity is more spread out over time.

To justify a value of 15.00, the RUC compared the survey code to top key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, intra-service time of 120 minutes, total time of 210 minutes) and noted that both services involve an identical amount of intra-service time and that 80 percent of the survey respondents who selected the top key reference code also indicated that the survey code is a more intense and complex procedure to perform. However, the reference code involves more total time. The RUC also compared the survey code to 2nd key reference code 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* (work RVU= 14.00, intra-service time of 90 minutes, total time of 183 minutes) and noted that the survey code involves much more intra-service time and somewhat more total time. 75 percent of the survey respondents who selected this reference code indicated the survey code was more intense and complex, however, the RUC recommendation of 15.00 has a lower intensity than the reference code. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. The RUC concluded that CPT code 93653 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 15.00 for CPT code 93653.**

93654 ***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 ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed***

The RUC reviewed the survey results from 63 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 18.10 for CPT code 93654. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 200 minutes of intra-service time and 33 minutes of immediate post-service time. The RUC noted that, unlike codes 93653 and 93655, the work of intracardiac electrophysiologic 3D mapping was already bundled into this service prior to the CPT revisions.

The specialties noted that the actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much more feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. The ablation treatment is much more intense in terms of risk of heart block and esophageal injury. Furthermore, while the physician is obtaining many more points to create the 3-dimensional map, they still need to make sure every one of those points are accurate as review of points is not automated.

In addition, the specialties noted that ventricular tachycardia patients are the most complicated, often with recurrent heart failure admissions and these patients typically have with an implantable defibrillator. The defibrillator must be turned off prior to the procedure and the patient requires more pre-service evaluation time to make sure that they are hemodynamically stable prior to and throughout the procedure.

To justify a work value of 18.10, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that the survey code involves 20 more minutes of intra-service time and 21 more minutes of total time. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200 minutes, total time of 355 minutes) and noted that although both services involve an identical amount of intra-service time, it would be appropriate to value the survey code somewhat lower due to the disparity in total time. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. The RUC concluded that CPT code 93654 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 18.10 for CPT code 93654.**

93655 ***Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 63 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 7.00 for CPT code 93655. The RUC recommends 60 minutes of intra-service time for this add-on service.

To support a work value of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00, intra-service and total time of 60 minutes) and noted that both add-on codes have identical times, whereas the reference code involves somewhat more intense physician work. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times. The RUC concluded that CPT code 93655 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 7.00 for CPT code 93655.**

93656 ***Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed***
The RUC reviewed the survey results from 61 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 17.00 for CPT code 93656. The RUC recommends 35 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time and 30 minutes of immediate post-service time. The RUC noted that CPT code 93656 was revised to now bundle the physician work of CPT codes 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* and 93662 *Intracardiac echocardiography during*

therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure), which previously were separately reported add-on services.

The specialties noted that the actual ablation portion of the procedure is more intense relative to when this procedure was last valued, since the cardiac electrophysiologist is now receiving much more feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery. Due to these recent improvements in technology, the lesions are now much more efficient and effective, but also because of that, the risk of causing collateral injury during the ablation delivery is much higher with each lesion delivery. The ablation treatment is much more intense in terms of risk of heart block and esophageal injury. Furthermore, while the physician is obtaining many more points to create the 3-dimensional map, they still need to make sure every one of those points are accurate as review of points is not automated.

To justify a value of 17.00, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that both services involve an identical amount of intra-service time, whereas the reference code involves slightly more total time and is also slightly more intense to perform. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200, total time of 355) and noted that the reference code involves 20 more minutes of intra-service time and 92 more minutes of total time, justifying a lower valuation for the survey code. The specialty noted and the RUC concurred that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to this survey code. The RUC concluded that CPT code 93656 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 17.00 for CPT code 93656.**

93657 ***Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 61 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 7.00 for CPT code 93657. The RUC recommends 60 minutes of intra-service time for this add-on service.

To support a work value of 7.00, the RUC compared the survey code to CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00, intra-service and total time of 60 minutes) and noted that both add-on codes have identical times, whereas the reference code involves somewhat more intense physician work. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times. The RUC concluded that CPT code 93657 should be valued at the 25th percentile work RVU as supported by the resurvey. **The RUC recommends a work RVU of 7.00 for CPT code 93657.**

Affirmation of RUC Recommendations
The RUC reviewed the specialty societies' request to affirm the recent RUC valuations for CPT codes 93613, 93621 and 93662. The RUC noted that for 93613, this is also the code's current 2021 CMS value. For code 93621, this service was surveyed for the October 2020 RUC meeting for CY 2022 and represents a reduction compared to the current 2021 CMS value.

For code 93662, the RUC recommendation would represent an increase compared to the current 2021 CMS value. In the CY 2021 Medicare Physician Payment Schedule Final Rule, CMS' rationale for not accepting the RUC recommendation and instead implementing a lower value for 93662 was the 45 percent decrease in total time from when the service was previously surveyed in 2000. The Agency's 1.44 work value was derived from using a work value crosswalk to 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).* Unfortunately, the coronary IVUS crosswalk code (92979) that CMS had used to determine an alternate valuation was flawed because the nature of the services performed, intensity and work involved are different, with intracardiac echocardiography (ICE) and intravascular ultrasound (IVUS) performed in different parts of the heart for different reasons. Coronary IVUS is performed inside the coronary arteries to guide diagnostic catheterization and/or percutaneous coronary interventions. ICE is used to provide high-resolution real-time visualization of cardiac structures, continuous monitoring of a catheter location within the heart. It commonly guides trans-septal puncture where the operator creates a hole in the septum of the heart to gain access to the other cardiac chambers on the other side of the heart and is useful for early recognition of procedural complications, such as pericardial effusion or thrombus formation. ICE remains highly technical in nature and requires the patient to be anesthetized, which is not required in IVUS use. ICE is most used with atrial fibrillation ablations, a highly technical and challenging service, this reinforces the intensity of ICE.

The RUC recommendation for CPT code 93662 was based on the survey 25th percentile work RVU from robust survey results of 42 cardiologists as well as a favorable comparison to code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and intra-service time of 20 minutes) and MPC code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and intra-service time of 30 minutes). Both reference services bracket code 93662 in both physician work and time.

The RUC recommends affirming the recent RUC-recommended work RVU of 5.23 for CPT code 93613, 1.75 for CPT code 93621 and 2.53 for CPT code 93662.

Practice Expense
No direct practice expense inputs are recommended for CPT codes 93653-93657 as they are facility-only services.

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

X. Relative Value Recommendations for *CPT 2023*

Endoscopic Bariatric Device Procedures (Tab 8)
Presenters: R. Bruce Cameron, MD (ACG), Seth A. Gross, MD (ASGE), Shivan Mehta, MD (AGA) and Ketan Sheth, MD (SAGES)

In February 2021, the CPT Editorial Panel approved the addition of two codes to report esophagogastroduodenoscopy, flexible, transoral with deployment and removal of intragastric bariatric balloon. CPT code 43235 was identified as being part of the same family of services.

43235 ***Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)***
The RUC reviewed the survey results from 54 gastrointestinal and endoscopic surgeons and bariatric surgeons and determined that maintaining the current work RVU of 2.09, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends 14 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait time, 15 minutes intra-service time and 12 minutes immediate post-service time. Pre-service time package 1 (Straightforward Patient/Straightforward Procedure (No anesthesia care)) and post-service time package 8A (IV Sedation/ Straightforward Procedure) are recommended as adjusted. CPT code 43235 is typically performed with either moderate sedation or anesthesia. In 2017, when moderate sedation was removed from GI endoscopy codes and other codes where moderate sedation was considered inherent to the procedure, it became historical precedent that moderate sedation is separately reported. Therefore, moderate sedation CPT codes 99152 and 99153 or 00731 would be reported typically on the same date with 43235 (43290 or 43291). No multiple procedures reduction policies apply.

To justify a work RVU of 2.09, the RUC compared CPT code 43235 to the top key reference service code 43202 *Esophagoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU = 1.72, 15 minutes intra-service time 47 minutes total time) and noted that the reference service has identical intra-service time but is less intense than the survey code and appropriately valued lower. The RUC also compared the survey code to the second key reference code 43216 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU = 2.30, 22 minutes intra-service time and 55 minutes total time) and noted that the reference service has more intra-service and total time and is appropriately valued higher than 43235.

For additional support, the RUC compared CPT code 43235 to MPC codes 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 15 minutes intra-service time and 49 minutes total time) and 64479 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level* (work RVU = 2.29, 15 minutes intra-service time and 49 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the survey code recommendation. The RUC concluded that the value of CPT code 43235 should be maintained at 2.09 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 2.09 for CPT code 43235.**

43290 ***Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon***
The RUC reviewed the survey results from 51 gastrointestinal and endoscopic surgeons and bariatric surgeons and concurred that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 31256

Nasal/sinus endoscopy, surgical, with maxillary antrostomy; (work RVU = 3.11, 30 minutes intra-service time and 83 minutes total time), which falls below the survey 25th percentile and has identical intra-service time, appropriately accounts for the physician work involved in this service. The RUC believed that the survey 25th percentile work RVU was too high in comparison to other services and agreed with the crosswalk to 31256. Alternative crosswalks were considered; however, the nasal endoscopy code, 31256, was deemed most clinically comparable and the value fits within the context of the EGD family. The RUC noted that in a comparison of recently RUC-reviewed 000-day global codes with similar intra-service and total times, the crosswalk value of 3.11 falls in the middle range in terms of work RVUs.

The RUC recommends 18 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait time, 30 minutes intra-service time and 20 minutes immediate post-service time, 76 minutes total time. Pre-service time package 2 (Difficult Patient/Straightforward Procedure (No anesthesia care)) and post-service time package 8A are recommended as adjusted. The typical patient is considered difficult based on an elevated BMI of 30-40. The RUC noted that the requested pre-service physician time components differ slightly from the package and specifically align with the traditional GI endoscopy pre-times: 18 minutes evaluation time, 3 minutes positioning time, and 5 minutes scrub/dress/wait time.

To justify the crosswalk value of 3.11 work RVUs, the RUC compared CPT code 43290 to key reference code 43226 *Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire* (work RVU = 2.24, 25 minutes intra-service time and 57 minutes total time) and noted that the reference service has less intra-service and total time and is a less complex procedure than the survey code and appropriately valued lower.

For additional support, the RUC compared CPT code 43290 to MPC codes 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU = 2.75, 30 minutes intra-service time and 76 minutes total time) and 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.46, 30 minutes intra-service time and 73 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the survey code recommendation. The RUC concluded that CPT code 43290 should be valued based on a direct work RVU crosswalk to CPT code 31256 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 3.11 for CPT code 43290.**

43291 ***Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)***

The RUC reviewed the survey results from 51 gastrointestinal and endoscopic surgeons and bariatric surgeons and determined that the survey 25th percentile work RVU of 2.80 appropriately accounts for the physician work involved in this service. The RUC recommends 18 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait time, 30 minutes intra-service time and 15 minutes immediate post-service time. The RUC noted that the requested pre-service physician time components specifically align with the rest of the gastrointestinal endoscopy pre-times: 18 minutes evaluation time, 3 minutes positioning time, and 5 minutes scrub/dress/wait time. Pre-service time package 2 and post-service time package 9A (General Anesthesia or Complex Regional Block/ Straightforward Procedure) are recommended as adjusted. The RUC noted that typically the patient is intubated and concurred that post-time package 9A, as adjusted per the survey, is most appropriate.

To justify a work RVU of 2.80, the RUC compared CPT code 43291 to the top key reference service code 43215 *Esophagoscopy, flexible, transoral; with removal of foreign body(s)* (work RVU = 2.44, 20 minutes intra-service time and 53 minutes total time) and noted that the reference service has ten minutes less intra-service time than the survey code and is appropriately valued lower.

For additional support, the RUC compared CPT code 43291 to MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.53, 30 minutes intra-service time and 61 minutes total time) and 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.46, 30 minutes intra-service time and 73 minutes total time) and noted that the multi-specialty points of comparison values have the same intra-service time and appropriately bracket the survey code recommendation. The RUC concluded that CPT code 43291 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.80 for CPT code 43291.**

Practice Expense
For CPT code 43290, the Practice Expense Subcommittee adjusted five minutes of clinical staff time between CA005 *Complete pre-procedure phone calls and prescription* (3 minutes) and CA035 *Complete pre-procedure phone calls and prescription* (2 minutes). The Subcommittee also verified that the new supply item, *Intragastric Balloon System,* is not reusable. When it is removed, the balloon is punctured so it cannot be reused in another patient. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 43290 and 43291 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Anterior Abdominal Hernia Repair (Tab 9)
Presenters: Charles Mabry, MD (ACS), Guy Orangio, MD (ASCRS), Don Selzer, MD (ACS), Steve Sentovich, MD (ASCRS) and Ketan Sheth, MD (SAGES)
Facilitation Committee #3

CPT Code 49565, *Repair recurrent incisional or ventral hernia; reducible*, was identified by the RUC as a service performed less than 50% of the time in the inpatient setting, included inpatient hospital E/M service codes and had Medicare utilization over 5,000. The stakeholder societies requested referral to CPT to update the descriptor of 49565 and other abdominal hernia codes to better describe these procedures as performed in current practice. As a result of the disparate site of service for anterior abdominal hernia repair codes, new codes were established and a 000-day global period was recommended. In addition, new codes for parastomal hernia repair, an add-on code to report removal of total or near total mesh, and a new code for placement of delayed mesh closure were established. The specialty societies collected data on typical site-of-service, hospital stays and associated Evaluation and Management (E/M) visits for the new codes through the survey process.

The specialty societies described the differences between the services included in this code family and explained that these CPT codes are generally differentiated by three factors: 1) whether the hernia is initial or recurrent; 2) whether the hernia is reducible or incarcerated/ strangulated; and 3) the total length of the hernia defect (< 3cm, 3-10cm, or > 10cm in length). Furthermore, two new codes were established to report parastomal hernia repair, which involves the repair of a hernia proximal to a pre-existing stoma. The specialty societies noted that each of these three factors impacts the work

involved in a hernia repair. The repair of an incarcerated/strangulated hernia involves more work than that of a reducible hernia; the repair of a larger hernia involves more work than that of a smaller hernia; and the repair of a recurrent hernia requires more work than repair of an initial hernia. This is illustrated by the fact that CPT code 49591 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial including placement of mesh or other prosthesis, when performed total length of defect(s); less than 3 cm, reducible* (recommended work RVU = 6.27, 45 minutes of intra-service time, 108 minutes of total time) has the lowest recommended work RVU of this code family and CPT code 49618 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed total length of defect(s); greater than 10 cm, incarcerated or strangulated* (recommended work RVU = 24.00, 180 minutes of intra-service time, 335 minutes of total time) has the highest recommended work RVU of this code family. In reviewing this code family, the RUC noted the importance of work RVU recommendations for individual codes and maintaining relativity across the entire code family (as shown in Table 1 below). The specialty societies noted – and the RUC concurred – that there is a dearth of available comparator codes for 000-day global codes with similar work RVUs and intra-service and total times for such major procedures and that this makes it particularly important to consider and maintain relativity within this code family.

The RUC acknowledged that the construction of the CPT codes in this family appropriately address the reporting of incarcerated/strangulated hernias. The introductory language for this code family states, "When both reducible and incarcerated/strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated/strangulated. For example, one 2 cm reducible initial incisional hernia and one 4 cm incarcerated initial incisional hernias separated by 2 cm would be reported as an initial incarcerated hernia repair with a maximum craniocaudad distance of 8 cm (49594)." As stated by the specialties, hernias of this sort are all generally the same piece of bowel herniating through the midline anterior abdominal wall defect and are not repaired separately; they are all the same hernia and if the interspace of the fascia were not intact (even for 1 cm), the entire single bulge would be considered incarcerated/strangulated. According to the specialty societies, it is also rare that if there are multiple hernias in the same proximity, there would be a separate hernia that is reducible and a separate hernia that is incarcerated/strangulated; it is most common that all the hernias would be incarcerated/strangulated as part of the same segment of bowel. Furthermore, in the scenario outlined in the CPT introductory language, if the 2 cm initial hernia (reducible) and the 4 cm initial hernia (incarcerated/strangulated) were separated and reported as 49591 and 49594 with April 2021 RUC recommended work RVUs, the total work RVU value would be **greater** (total work RVUs recommended = 20.27 for 49591 **and** 49594) than for just reporting the service as 49594 (recommended work RVU = 14.00). This would also be the case if the incarcerated/strangulated hernia were less than 3 cm in length and reported as 49592 (total work RVUs recommended = 15.27 for 49591 **and** 49592).

Table 1: Anterior Abdominal Hernia Repair: Work RVU Recommendations		
CPT Code	**DESC**	**Recommended Work RVU**
49591	**Initial,** Reduc, < 3cm	**6.27**
49613	**Recurrent,** Reduc, < 3cm	**7.75**
49592	**Initial, I/S,** < 3cm	**9.00**
49614	**Recurrent, I/S,** < 3cm	**10.79**
49593	**Initial,** Reduc, 3-10cm	**10.80**
49615	**Recurrent,** Reduc, 3-10cm	**12.00**
49621	**Parastomal**, Reduc	**14.24**
49594	**Initial, I/S,** 3-10cm	**14.00**
49595	**Initial,** Reduc, > 10cm	**14.88**
49616	**Recurrent, I/S,** 3-10cm	**16.50**
49617	**Recurrent,** Reduc, > 10cm	**16.97**
49622	**Parastomal**, **I/S**	**18.00**
49596	**Initial, I/S,** > 10cm	**20.00**
49618	**Recurrent, I/S, > 10cm**	**24.00**
+49623	Removal of total or near-total non-infected mesh	**5.00**

Table 2: Mesh for Delayed Closure of Defect(s): Work RVU Recommendations		
CPT Code	**DESC**	**Recommended Work RVU**
15778	Implantation of absorbable mesh or other prosthesis	**8.00**

Initial Abdominal Hernia Repair

49591 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible***
The RUC reviewed the survey results from 39 surgeons for CPT code 49591 and determined that the survey 25th percentile work RVU of 6.27 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 3 minutes of pre-service

positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 20 minutes of immediate post-service time, and 108 minutes of total time. The specialty societies noted that this service involves the repair of the smallest type of an initial reducible hernia.

The typical patient is discharged on the same day and therefore there are no post-operative same day visits associated with 49591. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted CPT add-on code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 6.27, the RUC compared CPT code 49591 to top key reference service CPT code 31600 *Tracheostomy, planned (separate procedure)* (work RVU = 5.56, 30 minutes of intra-service and 120 minutes of total time) and second key reference service CPT code 43210 *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed* (work RVU = 7.75, 60 minutes of intra-service time and 148 minutes of total time) and noted that the surveyed code is appropriately bracketed by these two services based on the complexity of physician work and intra-service time required to perform these services. The RUC also compared CPT code 49591 to MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 45 minutes of intra-service and 118 minutes of total time). The RUC determined that these values support the recommended work RVU and noted that CPT code 49591 requires the same 45 minutes of intra-service time as MPC code 52352 but slightly less total time and support the slightly lower work RVU recommendation. **The RUC recommends a work RVU of 6.27 for CPT code 49591**.

49592 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 39 surgeons for CPT code 49592 and determined that the survey 25th percentile work RVU of 9.00 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 30 minutes of immediate post-service time, and 143 minutes of total time. The specialty societies noted that the repair of an incarcerated/strangulated hernia requires more intra-service time and is more complex than the repair of a reducible hernia of the same or similar size. In addition, the specialties indicated that the repair of an incarcerated/strangulated hernia is typically performed laparoscopically and typically involves a loop of bowel which must be pulled down through the hernia and could potentially bleed. The high intensity of this service necessitates an overnight stay to monitor the abdomen and particularly the bowel that has been drawn through the hernia. Pain and bowel function is also a significant concern that requires close monitoring.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient

and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the survey immediate post-service time (total of 30 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 9.00, the RUC compared CPT code 49592 to CPT code 43276 *Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged* (work RVU = 8.84, 60 minutes of intra-service and 123 minutes of total time) and CPT code 33954 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older* (work RVU = 9.11, 60 minutes intra-service and 178 minutes of total time). The RUC determined that these services include the same intra-service time as the surveyed code and appropriately bracket the recommend work RVU of CPT code 49592. **The RUC recommends a work RVU of 9.00 for CPT code 49592**.

49593 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, reducible***
The RUC reviewed the survey results from 41 surgeons for CPT code 49593 and determined that the survey 25th percentile work RVU of 10.80 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time, 30 minutes of immediate post-service time, and 175 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia of this size. The evaluation time was reduced from Pre-time Package 3 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review

orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the survey immediate post-service time (total of 30 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 10.80, the RUC compared CPT code 49593 to top key reference service 11006 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure* (work RVU = 13.10, 120 minutes of intra-service and 270 minutes of total time) as well as 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 and 141 minutes of total time) and noted that the recommended work RVU of 10.80 is appropriately higher than that of MPC code 36906 given 49593's higher total time and is appropriately lower than that of top key reference service 11006 given 49593's lower intra-service and total time. **The RUC recommends a work RVU of 10.80 for CPT code 49593**.

49594 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 41 surgeons for CPT code 49594 and determined that the survey 25th percentile work RVU of 14.00 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 40 minutes of immediate post-service time, and 225 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia this size. The evaluation and scrub/dress/wait times were reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99225/99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient

and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 20 minutes for 99225/99232 has been added to the immediate post-service time (total of 40 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 14.00, the RUC compared CPT code 49594 to top key reference service CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and 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 of intra-service and 166 minutes of total time) and noted that these codes bracket CPT code 49594 with appropriate work RVUs and noted that the recommended work RVU of 14.00 is appropriately higher than that of MPC code 37244 given 49594's higher intra-service and total time and is appropriately lower than that of top key reference service 11005 given 49594's lower total time. **The RUC recommends a work RVU of 14.00 for CPT code 49594**.

49595 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, reducible***
The RUC reviewed the survey results from 40 surgeons for CPT code 49595 and determined that the survey 25th percentile work RVU of 14.88 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 40 minutes of immediate post-service time, and 230 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia this size. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99225/99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging

studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 20 minutes for 99225/99232 has been added to the immediate post-service time (total of 40 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 14.88, the RUC compared CPT code 49595 to second key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and noted that both services require similar physician work and time to perform. The RUC also referenced 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 of intra-service and 166 minutes total time) and noted that 20 percent of survey respondents determined that 49595 is much more complex than second key reference service 11005 and 60 percent of survey respondents determined that 49595 is somewhat more complex than 11005, which supports a slightly higher work RVU value for 49595. The higher recommended intra-service and total time for 49595 supports a higher work RVU value than 37244. **The RUC recommends a work RVU of 14.88 for CPT code 49595**.

49596 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 40 surgeons for CPT code 49596 and determined that the survey median work RVU of 20.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 160 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99233 post-operative observation visit, and 310 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen and that there may be multiple defects involved in a hernia this size. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the at the level of 99233 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (high complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Patients undergoing the repair of this size of hernia will require significant postoperative care on the same day to address pain control, review vital signs and fluid status commonly affected by repair of larger hernias, and eliminate concerns for bleeding and infection more common with larger or more numerous incisions. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 20.00, the RUC compared CPT code 49596 to top key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and second key reference service 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)* (work RVU = 20.12, 232 minutes of intra-service and 362 minutes of total time) and noted that the recommended intra-service and total times support a work RVU higher than that of top key reference service 11005. The RUC also noted that 44 percent of survey respondents determined that 49596 is much more complex than second key reference service 61624 and 44 percent of survey respondents determined that 49596 is somewhat more complex than 61624, supporting a slightly lower work RVU despite the differences in intra-service and total time. **The RUC recommends a work RVU of 20.00 for CPT code 49596.**

Recurrent Abdominal Hernia Repair

49613 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible***
The RUC reviewed the survey results from 41 surgeons for CPT code 49613 and determined that the survey 25th percentile work RVU of 7.75 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 20 minutes of immediate post-service time, and 135 minutes of total time. The RUC noted that this service involves the repair of the smallest size of a *recurrent* hernia and that there would be additional time and intensity associated with this service over CPT code 49591 because of the previous procedure. The specialty societies noted that this service is typically performed laparoscopically along the midline of the abdomen. The evaluation time was reduced from Pre-time Package 3 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and

secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The typical patient is discharged on the same day and therefore there are no post-operative visits associated with 49613. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 7.75, the RUC compared CPT code 49613 to CPT code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 7.55, 45 minutes of intra-service and 135 minutes of total time), CPT code 52240 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; large bladder tumor(s)* (work RVU = 7.50, 60 minutes of intra-service and 133 minutes of total time) and MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50, 60 minutes of intra-service and 133 minutes of total time) and noted that the work RVUs, intra-service times and total times in this range of codes supports the work RVU recommendation for CPT code 49613 and that the added work associated with a recurrent hernia with respect to a reducible hernia places the recommended work RVU within appropriate rank order in this code family. **The RUC recommends a work RVU of 7.75 for CPT code 49613**.

49614 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 41 surgeons for CPT code 49614 and determined that the survey 25th percentile work RVU of 10.79 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 75 minutes of intra-service time, 30 minutes of immediate post-service time, and 165 minutes of total time. The specialty societies specified that this service involves a recurrent hernia (as opposed to an initial hernia) and that involves another opening adjacent to the previously placed mesh and scar tissue and that the service is typically performed laparoscopically and involves working around a piece of incarcerated/strangulated bowel. These factors increase the time and intensity involved in performing the service. The evaluation and scrub/dress/wait times were reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus,

intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the immediate post-service time (total of 30 minutes). The RUC noted that the recommended work RVU of 10.79 places this code in appropriate rank order within this code family with respect to overall intensity. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection(List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 10.79, the RUC compared CPT code 49614 to top key reference service CPT code 21811 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs* (work RVU = 10.79, 120 minutes of intra-service and 220 minutes of total time) and noted that the surveyed code requires less intra-service time but is much more intense, thus appropriate to be valued the same. Of the respondents who chose 21811 as the key reference service, 67% indicated CPT code 49614 requires more mental effort, technical skill and physician stress than CPT code 21811.

For additional support, the RUC referenced 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 of intra-service and 141 minutes of total time). **The RUC recommends a work RVU of 10.79 for CPT code 49614**.

49615 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, reducible***
The RUC reviewed the survey results from 43 surgeons for CPT code 49615 and determined that the survey 25th percentile work RVU of 12.00 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 100 minutes of intra-service time, 30 minutes of immediate post-service time, and 190 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The evaluation and scrub/dress/wait times were reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient

relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will stay overnight or longer and there will typically be a visit later the same date of the procedure at the level of 99224/99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Per CMS policy for reporting postoperative work for 23-hour stay procedures, the intra-service time of 10 minutes for 99224/99231 has been added to the immediate post-service time (total of 30 minutes). The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 12.00, the RUC compared CPT code 49615 to top key reference service 11006 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure* (work RVU = 13.10, 120 minutes of intra-service and 270 minutes of total time) and second key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time), both which require more physician work and time than 49615; thus it is appropriately valued slightly lower. **The RUC recommends a work RVU of 12.00 for CPT code 49615**.

49616 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 43 surgeons for CPT code 49616 and determined that the survey 25th percentile work RVU of 16.50 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 140 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 275 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the level of 99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. The insertion of mesh or other prosthesis is now bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 16.50, the RUC compared CPT code 49616 to top key reference service 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU = 20.00, 173 minutes of intra-service time and 323 minutes of total time) and the second key reference service 21813 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs* (work RVU = 17.61, 210 minutes of intra-service and 310 minutes of total time) and noted that the surveyed code requires less physician time and work; thus it is appropriately valued lower.

For additional support, the RUC referenced 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 of intra-service and 166 minutes of total time) and noted that the surveyed code requires more physician work and time to perform, thus is valued higher. **The RUC recommends a work RVU of 16.50 for CPT code 49616**.

49617 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, reducible***
The RUC reviewed the survey results from 42 surgeons for CPT code 49617 and noted that the survey 25th percentile work RVU recommendation would have created a rank order anomaly within the recommended work RVU values across this code family. The specialty societies noted that while the hernia repair associated with CPT code 49616 involves an incarcerated/strangulated hernia, the hernia repair associated with CPT code 49617 involves a significantly larger area of repair and involves multiple hernias in a line. However, the RUC determined that the survey median work RVU value of 18.53 overvalues the work associated with performing this procedure. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the

abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC determined that a direct work RVU crosswalk to CPT code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU = 16.97, 150 minutes of intra-service and 210 minutes of total time) appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 28 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 288 minutes of total time for CPT code 49617.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the level of 99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. The insertion of mesh or other prosthesis is bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 16.97, the RUC compared CPT code 49617 to second key reference service 11006 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure* (work RVU = 13.10, 120 minutes of intra-service and 270 minutes of total time) and top key reference service 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) and noted that the higher intra-service time and the complexity associated with the repair of a recurrent abdominal hernia greater than 10 cm in length supports a higher work RVU than the key reference services. **The RUC recommends a work RVU of 16.97 for CPT code 49617**.

49618 ***Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated***

The RUC reviewed the survey results from 42 surgeons for CPT code 49618 and determined that the survey median work RVU of 24.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 335 minutes

of total time. The specialty noted that the hernia repair associated with this service involves a large and recurrent hernia which presents several challenges, including navigating previous repairs (including scar tissue and previously placed mesh) and addressing the piece of bowel that is incarcerated or strangulated.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later the same date of the procedure at the level of 99233 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (high complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family. Patients undergoing the repair of this size of hernia will require significant postoperative care on the same day to address pain control, review vital signs and fluid status commonly affected by repair of larger hernias, and eliminate concerns for bleeding and infection more common with larger or more numerous incisions. The insertion of mesh or other prosthesis is bundled into this service; the work associated with the placement of mesh or other prosthesis was previously reported separately with deleted add-on CPT code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88).

To support a work RVU of 24.00, the RUC compared CPT code 49618 to top key reference service CPT code 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)* (work RVU = 20.12, 232 minutes of intra-service and 362 minutes of total time) and second key reference service CPT code 21813 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs* (work RVU = 17.61, 210 minutes of intra-service and 310 minutes of total time) and noted that the work associated with 49618 is significantly more complex given the size, recurrence, and incarceration/strangulation and that this service is the most complex in the rank order of this code family. **The RUC recommends a work RVU of 24.00 for CPT code 49618.**

Parastomal Hernia Repair

49621 ***Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible***
The RUC reviewed the survey results from 39 surgeons for CPT code 49621 and determined that the specialty recommended survey median work RVU of 15.50 overvalues the work associated with this service. However, the RUC determined that the survey 25th percentile work RVU of 13.50 undervalues the work associated with this service and would create a rank order anomaly within this code family.

The RUC determined that a direct work RVU crosswalk to CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 14.24, 120 minutes of intra-service and 265 minutes of total time) appropriately reflects the relative work required to perform this service and places CPT code 49621 in appropriate rank order within this family of anterior abdominal hernia repair codes. The

RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99231 post-operative observation visit, and 235 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later of the same date at the level of 99231 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (low complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family.. The RUC noted that the parastomal abdominal hernia occurs proximal to a pre-existing stoma and colostomy and requires the maintenance of an abdominal defect to maintain the colostomy and that these factors make it a more complex service than a typical reducible abdominal hernia repair.

To support a work RVU of 14.24, the RUC compared CPT code 49621 to CPT code 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 14.75, 135 minutes intra-service time and 203 minutes of total time) and determined that the work RVU of 14.75 is appropriately higher than the recommended work RVU of 14.24 for 49621. **The RUC recommends a work RVU of 14.24 for CPT code 49621**.

49622 ***Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; incarcerated or strangulated***

The RUC reviewed the survey results from 39 surgeons for CPT code 49622 and determined that the survey median work RVU of 18.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 285 minutes of total time. The specialty societies noted that this service is typically performed laparoscopically. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data. The positioning time was increased from the pre-time package to account for laparoscopic/robotic anterior abdominal hernia repair positioning: The patient will initially be positioned supine and upper extremity intravenous and arterial access points are dressed, padded and secured. The arms are padded and tucked at the patient's sides. The patient must be secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the

procedure to use gravity to assist with shifting the abdominal contents. There is also consideration of positioning the patient relative to: laparoscopy equipment, including lines and video equipment and anesthesia lines relative to the rest of the equipment.

The RUC noted that the typical patient will be admitted as inpatient and there will typically be a visit later on the same date at the level of 99232 to monitor for problems such as ileus, intestinal ischemia, urinary retention and pain control; review data (eg, diagnostic and imaging studies) not available at the unit; communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise diagnosis and treatment plan(s) (moderate complexity MDM); discuss diagnosis and treatment options with the patient and/or family; communicate with other health care professionals as necessary; write and/or review orders, complete medical record documentation; address interval data obtained and reported changes in condition; communicate results and additional care plans to other health care professionals and to the patient and/or family.. The RUC noted that the parastomal abdominal hernia occurs proximal to a pre-existing stoma and colostomy and requires the maintenance of an abdominal defect to maintain the colostomy and that these factors make it a more complex service than a typical reducible abdominal hernia repair. The incarcerated/strangulated piece of bowel necessarily requires more work for 49622 than that associated with repair of a reducible parastomal hernia for 49621.

To support a work RVU of 18.00, the RUC compared CPT code 49622 to top key reference service CPT code 21813 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs* (work RVU = 17.61, 210 minutes of intra-service and 310 minutes of total time) and noted that of the survey respondents who chose 21813 as the key reference service, 100% indicated that the surveyed code was more intense and complex on all measures. Therefore, although the surveyed code requires slightly less intra-service time than CPT code 21813, it is appropriate that it is valued slightly higher since it is more intense and complex. The RUC compared 49622 to the second key reference service CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU = 20.00, 173 minutes of intra-service and 323 minutes of total time) and noted that 49622 requires less physician work and time, thus is valued appropriately slightly lower than 33891. The RUC noted that 49622 is valued appropriately higher than 49621 given the piece of incarcerated/strangulated bowel associated with 49622. **The RUC recommends a work RVU of 18.00 for CPT code 49622**.

Removal of Mesh or Other Prosthesis

49623 ***Removal of total or near-total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)***The RUC discussed the subject of mesh implantation and removal at length. The specialties indicated that when add-on CPT code 49568 was created in 1993, mesh implantation with hernia repairs was not typical. This is supported by the typical patient described in 1993 as having a 10 cm midline incisional hernia – a very large hernia. With research on the causes of hernia recurrence, changes in technology and development of new types of mesh or other prosthesis, implantation of mesh is now typical for all types of hernias and all sizes to reduce the incidence of recurrence. This was supported by the literature submitted with the February 2021 CCA. However, the specialties also informed the RUC that mesh removal is not always required and is not typical. Technology and research have developed types of mesh that are now being implanted which are incorporated into the abdominal wall, reducing the risk of infection, complications, and recurrence. When mesh removal is indicated, it is typically due to hardening and fracturing of aged mesh, or when gross contamination and infection has

occurred (eg, enterocutaneous fistula involving the mesh). For example, a recurrent hernia repair may require removal of fractured, brittle (old technology) mesh many years after an open repair following a colectomy. This work is typically significant, in that the mesh is often integrated with the abdominal wall or adhered to intestine, and involves removal of all of the mesh, not just a small portion. An add-on code to report mesh removal prior to hernia repair, when required, allows for accurate reporting of this work only when performed. The RUC was concerned that the code descriptor may be reported no matter how much mesh is removed, including minimal trimming. The specialty societies explained that the purpose of CPT code 49623 is not to report mesh trimming or adjustment but the total or near total removal of mesh. The specialty society noted that this code should be rarely used as the total or near total removal of mesh is extremely invasive and damaging. **The specialty societies recommended - and the RUC agreed - to refer this issue to the CPT Panel to editorially revise the CPT guidelines for the Anterior Abdominal Hernia Repair subsection to specify "total or near total" mesh removal and revise the code descriptor for CPT code 49623 to specify "total or near total non-infected" mesh removal.**

The RUC reviewed the survey results from 150 surgeons for CPT code 49623 and determined that the survey median and 25th percentile work RVU of 5.00 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes of intra-service and total time.

To support a work RVU of 5.00, the RUC compared CPT code 49623 to the top key reference service 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection)* (work RVU = 5.00, 60 minutes of intra-service and total time), the second key reference service CPT code 35572 *Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery)* (work RVU = 6.81, 60 minutes of intra-service and total time) and noted that the survey respondents indicated the intensity and complexity of CPT code 49623 was greater that both CPT code 11008 and CPT code 35572. Both of the reference codes are performed via an open approach with direct visualization, while 49623 will typically be performed via a laparoscopic or robotic approach internally. The RUC also compared CPT code 49623 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU = 4.13, 40 minutes of intra-service and total time) and noted that a recommended work RVU of 5.00 is appropriately higher than that of 34812 given the higher intra-service time and relative work.

As additional support, the RUC considered CPT code 57267, *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88, 45 minutes of intra-service and total time) and CPT code 63295, *Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)* (work RVU = 5.25, 45 minutes of intra-service time and 55 minutes total time) which bracket the work included in CPT code 49623. **The RUC recommends a work RVU of 5.00 for CPT code 49623.**

Implantation of Absorbable Mesh or Other Prothesis for Delayed Closure

15778 ***Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma***
The RUC reviewed the survey results from 36 surgeons for CPT code 15778 and determined that the survey 25th percentile work RVU of 8.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232 post-operative observation visit, and 213 minutes of

total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as to not exceed survey median data.

The RUC agreed with the specialties that the typical patient requiring this procedure will have a large abdominal wall defect as a result of necrotizing infection and extensive debridement of all involved skin, subcutaneous tissue, fascia and muscle. For some patients, the external genitalia and perineum may also be involved. These patients will all have inpatient status and will require a visit later on the same date at the level of 99232 to monitor the sutured wound edges of skin/mesh for swelling and pulling and to monitor for pain control. Intake/output and vital signs are evaluated, including fluid and electrolyte status and renal function. Orders for prophylaxis for DVT and beta-blockers are reviewed and adjusted as needed. The surgeon will communicate with other health care professionals and with patient and/or family; review medical records and data available on the unit; perform a medically appropriate examination; consider relevant data, options, and risks; formulate and/or revise treatment plan(s) (moderate complexity MDM); and complete medical record documentation.

The RUC reviewed the top survey key reference services and agreed they were poor comparators because the intra-times and total times were much lower. To support a work RVU of 8.00, the RUC compared CPT code 15778 to MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50, 60 minutes of intra-service and 133 minutes of total time) and agreed that 15778 was appropriately bracketed by these two codes using magnitude estimation. **The RUC recommends a work RVU of 8.00 for CPT code 15778**.

RUC Referral to CPT
The RUC recommends CPT code 49623 be referred to CPT to editorially revise the guidelines to specify "total or near total non-infected" mesh removal and revise the descriptor for CPT code 49623 to specify "total or near total non-infected" mesh removal. *The CPT Editorial Panel incorporated these changes at their May 2021 meeting.*

Work Neutrality
The RUC's recommendation for this code family will result in an overall work savings that should be redistributed back to the Medicare conversion factor. The specialty society survey was conducted for all the base codes as 000-day global. This contrasts with the former code structure for this family where all the hernia repair codes had a 090-day global period, and as a result, post-operative visits after the date of the procedure will now be separately reported, when performed. When evaluating work neutrality, AMA staff performed several analyses, including an analysis assuming all bundled visits other than discharge services would continue to be separately reported, to determine whether the RUC recommendation was work neutral. Under all scenarios, including assumptions that all E/M visits will be separately reported using the current CMS values, the RUC recommendation for this code family would be work neutral.

Practice Expense
The Practice Expense (PE) Subcommittee agreed with the special society submitted standard 090-day global period clinical staff inputs as the conversion of this code family from 090-day to 000-day global period does not impact the fact that these are major surgical procedures. The PE Subcommittee removed medical supply item SA054 *Post-Operative Incision Care Suture Pack* from the submitted practice expense inputs because SA054 must be allocable to the service period; this would not be possible as this code family consists of 000-day global codes and one ZZZ code. The PE Subcommittee recommended that the specialties address post-operative work and practice expense needs such as suture removal through the CPT process. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Orthoptic Training (Tab 10)
Presenters: Charles Fitzpatrick, OD (AOA), David B. Glasser, MD (AAO) and Ankoor R. Shah, MD (AAO)

CPT code 92065 was identified in October 2019 as Harvard Valued utilization over 30,000. The Workgroup requested action plans to examine this service. In January 2020, the RUC recommended that this service be referred to CPT May 2020. This service with an "and/or" connector should be two different codes given their different patient populations and techniques used for the treatment. For that reason, this code should go back to CPT for a descriptor edit as well as creation of separate codes. At the October 2020 RUC meeting, based on pre-facilitation by the RUC, the specialty societies indicated their intent to take this code back to the CPT Editorial Panel again to create two separate codes. The societies requested referral to CPT and plan to submit a new code change application for the February 2021 CPT Editorial Panel meeting. During review and analysis of the survey, it became evident that this service is delivered in two different ways. Because of this, it is necessary to create two codes to delineate when the training is provided directly by the physician/qualified healthcare professional (QHP) and when it is provided by a technician under the supervision of the physician/QHP. Doing so will ensure more accurate valuation of both work and practice expense associated with this service. The RUC supports creation of a companion code and concurs that code 92065 should be referred to the February 2021 CPT Editorial Panel meeting for CPT 2023. In February 2021, the CPT Editorial Panel revised code 92065 and created a new code to describe this service under the supervision of a physician or qualified health care professional.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to support a change in physician work for CPT code 92065.The compelling evidence is based on documentation in the peer-reviewed ophthalmological literature that there have been changes in physician work due to new techniques, knowledge, and technology that have added to the complexity of orthoptic training.

The Convergence Insufficiency Treatment Trial (CITT) was an NEI-sponsored multi-center randomized clinical trial which compared traditional pencil push-up therapy with three additional treatments for symptomatic convergence insufficiency: (1) home-based computer vergence and accommodation exercises, (2) office-based, supervised vergence and accommodative therapy plus computer training with home reinforcement, and (3) office-based placebo therapy with home reinforcement. With results first published in 2008, the CITT demonstrated that office-based vergence/accommodative therapy with home reinforcement was statistically significantly more effective than placebo and each of the other treatment regimens studied in improving both the symptoms and clinical signs associated with symptomatic convergence insufficiency. This transformed orthoptic training methodology. Today's office-based training employs new training exercises and computer equipment/software that differ from those manual and mechanical devices in use in 1992 when the procedure was first valued in the Harvard study. The training exercises and computer equipment/software also differ from those in use in 2002, prior to publication of the CITT, when the PE was last updated to include computer and VDT software.

Current therapy for non-strabismic accommodative and vergence disorders including convergence insufficiency involves highly specific, sequential, sensory-motor-perceptual stimulation paradigms and regimens. It incorporates purposeful, controlled, and scientifically based manipulations of target blur, disparity, and proximity, with the aim of normalizing the accommodative system, the vergence system, and their mutual interactions. In addition, other sources of sensory information, such as kinesthesia and audition correlated to the accommodative and vergence states (e.g., position, innervation, effort, etc.) can provide cue reinforcement. It involves oculomotor integration with the

head (i.e., eye-head coordination), neck (i.e., proprioceptive information), limbs, and overall body, with information from the other sensory modalities, producing temporally efficient, coordinated behavior.

The RUC agreed that compelling evidence has been met due to a change in physician work because of new techniques, knowledge, and technology. However, it was noted that compelling evidence was not necessarily required considering the service is going to be performed only 45 percent of the time at the frequency it was done before, while 55 percent of the time it is going to be a PE-only service, resulting in a total reduction in work RVUs. That is, even though the value is increasing from the current work RVU of 0.37 to 0.71, the total expenditure will decrease. The estimate of the 45 percent and 55 percent split was considered tenuous, however, and the RUC proceeded with approval of compelling evidence.

92065 ***Orthoptic training; performed by a physician or other qualified health care professional***
CPT code 92065 involves the physician/QHP personally administering neurosensory and neuromuscular training activities to develop, rehabilitate and enhance visual skills and processing. The use of lenses, prisms, filters, specialized instruments, and computer programs is an integral part of the therapy protocol. The typical patient has convergence insufficiency resulting in discomfort, strain, blur, headache, diplopia and difficulty with reading and other near tasks. Exercises are taught to the patient by the physician/QHP, including physician review of the patient's understanding of the plan and ability to perform the exercises correctly.

The RUC reviewed the survey results from 34 ophthalmologists and optometrists and determined that the survey 25th percentile work RVU of 0.71 appropriately accounts for the physician work involved in this service. The RUC recommends 2 minutes pre-service time, 30 minutes intra-service time and 4 minutes post-service time. CPT code 92065 is not a time-based code; it is a training procedure that is reported only once a day, unlike therapy sessions that can be reported several times in 30-minute increments on a single day. Optometrists are the dominant specialty, with 97.4 percent of Medicare claims in 2019. They were also the dominant survey responders, with 73.5 percent of the responses. The recommendations are based on the entire survey dataset as a better reflection of the overall times and values for this code, including a median intra-service time of 30 minutes.

The RUC noted that the procedure is performed on the same day as an office or eye Evaluation and Management (E/M) visit 39 percent of the time and with a sensorimotor exam (CPT code 92060) 15 percent of the time, which includes pre- and post-service work like that of an office visit. Therefore, the survey pre- and post-times were reduced from 10 to 2 minutes to not duplicate any work provided with the E/M service. During the office visit or sensorimotor exam, the physician develops a treatment plan consisting of a sequence of neurosensory and neuromuscular activities for the patient. The survey post-time was reduced from 9 to 4 minutes. This time is required to record patient performance into the medical record, develop a treatment plan for the next training session, enter that plan into the medical record, and generate a letter to the referring physician.

To justify a work RVU of 0.71, the RUC compared the survey code to the key reference service codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 2 minutes pre-service time, 15 minutes intra-service time and 3 minutes immediate post-service time) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU = 0.70, 2 minutes pre-service

time, 11 minutes intra-service time and 3 minutes immediate post-service time) and noted that the intra-service times do not match and the survey code has both greater intra-service and total time than the reference services. The RUC also noted, however, that the survey code is closely bracketed by the work values of MPC code 99212 and MPC code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 2 minutes pre-service time, 20 minutes intra-service time and 4 minutes immediate post-service time).

For additional support, the RUC compared the survey code to HCPCS code G0108 *Diabetes outpatient self-management training services, individual, per 30 minutes* (work RVU = 0.90, 2 minutes pre-service time, 30 minutes intra-service time and 5 minutes immediate post-service time) and noted the G-code is also a training code with identical intra-service time, nearly identical total time, yet a higher work value. The RUC noted that the recommended value is less than the median of the 37 XXX global codes in the RUC database with work values assigned within the last 10 years and 30 minute intra-service time (range 0.55 to 4.00, median 1.48 work RVUs). The RUC concluded that CPT code 92065 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.71 for CPT code 92065.**

92066 *Orthoptic training; under supervision of a physician or other qualified health care professional*

The new CPT code 92066 specifies training under supervision of a physician or other qualified health professional. The code has practice expense (PE) inputs only and was not surveyed for physician work. This PE-only code requires identical work and intra-service time as code 92065 but with a different health care professional, typically the technician, L038A *COMT/COT/RN/CST*, performing the service; thus, there are 30 minutes allocated to CA021 *Perform procedure/service---NOT directly related to physician work time.* Only one session per day is reported. The anticipated course of treatment is 1-2 sessions per week over a three-month period based upon the Convergence Insufficiency Treatment Trial (CITT).

The PE Subcommittee thoroughly reviewed the practice expense recommendations for the companion codes and approved the inputs with few modifications. For the medical supply inputs, the PE Subcommittee determined that they are not redundant and are disposable. There was one adjustment to supply item SK057 *Paper, laser* to accurately reflect the type of paper that is utilized for the patient to be working on cheiroscope and other visual motor skills. The updates to equipment reflect new changes in management of convergence insufficiency. The equipment location has changed from EL006 *lane, screening (oph)* to a room with table and 4 chairs to reflect the typical practice more accurately. The time applied for EF043 *Set of 8 chairs* was reduced by half to reflect the use of 4 chairs during the activities rather than the full 8 chairs. The PE Subcommittee recommends two new equipment inputs for this service, Pro Vision Therapy Starter System Model VTSSP and Sanet Vision Integrator display/software. The starter system contains several devices to stimulate fusion/ convergence. Various components of this system are used as part of training for these vision activities. It is entirely reusable and thus considered as an equipment input for valuation. EQ232 *stereo trainer (wheatstone)* was removed to avoid duplication with the contents of the starter system. The Sanet Vision Integrator display/software is used as part of visual activities to address near acuity and depth perception issues. This replaces ED009 *computer and VDT and software* which was a more generic equipment previously included when the code was initially valued. Two paid invoices are included with this recommendation for these items. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee for CPT codes 92066 and 92065.**

New Technology
CPT codes 92066 and 92065 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Caregiver Behavior Management Training (Tab 11)
Presenters: Sherry Barron-Seabrook, MD (AACAP), Stephen Gillaspy, PhD (APA), Richard Loren, PhD (APA), Eileen Myers, MPH, LDN (AND), Karen Smith, MS (AND), Scott Sperling, PsyD (APA) and Kai-ping Wang, MD (AACAP)

In February 2021, the CPT Editorial Panel created two new group caregiver behavior management training codes. CPT codes 96202 and 96203 are used to report the total duration of face-to-face time spent by the physician or other qualified healthcare professional (QHP) providing the group training session.

96202 ***Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes***
The RUC reviewed the survey results from 75 psychologists, child and adolescent psychiatrists, and dieticians with the understanding that the survey respondents were asked to evaluate the group service in total and not based on an individual group participant. Also, a custom survey question was added that asked respondents to provide the average number of patients that were represented at a typical caregiver behavior management group session. The question yielded a median response of six patients. The intent was to obtain per session data on the service, that could then be divided by the average number of patients to yield the per patient data. This methodology for surveying time-based group codes has recent precedent when it was relied on for group health behavior intervention codes 96164-96165; CMS accepted the HCPAC's recommendation in CY2020 rulemaking.

The purpose of this service is to train caregivers how to structure the environment to actively provide for and reinforce desired behaviors, reduce the negative impacts of the patient's diagnosis on patient's daily life, develop highly structured technical skills to better manage specific behaviors and support the compliance with the patient's treatment and clinical plan of care. While this service is performed without the patient present, the goals and outcomes are solely for the therapeutic benefit of the identified patient. This service is a skills training process; it is not a support group or a lecture. While the interventions are evidence-based, they are not scripted. The physician or other qualified healthcare professional must rely on their expertise and ability to integrate multiple factors, while effectively capitalizing upon the group dynamics to personalize the intervention and optimize treatment outcomes.

The specialty societies noted that although the median survey respondent has not performed this service in the past 12 months, likely due to the ongoing COVID-19 public health emergency, 2/3rds of the survey respondents have performed this service in the past 5 years and the other survey respondents were instructed to only complete the survey if they were sufficiently familiar with the service.

The RUC agreed that the median per session work value of 2.60 RVUs converted to the per patient work value of 0.43 RVUs by dividing by the typical six patients would appropriately value this service. The RUC recommends 2 minutes pre-service time, 10 minutes intra-service time, 3 minutes post-service time, for 15 minutes total time for survey code 96202. These physician/QHP times were a result of converting the median group survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service and converting them to per patient times and rounding to the

nearest whole number. The RUC compared the survey code to 2nd key reference code 90847 *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* (work RVU = 2.50, intra-service time of 50 minutes, total time of 76 minutes) and noted that for a typical group size, the survey code would involve 10 more minutes of intra-service time,14 more minutes of total time. In addition, 76 percent of the respondents that selected the 2nd key reference code indicated the survey code is more intense and complex to perform. For additional reference, the RUC compared the survey code to CPT code 90839 *Psychotherapy for crisis; first 60 minutes* (work RVU = 3.13, intra-service time of 60 minutes, total time of 90 minutes) and noted that for a typical group size both services would have identical intra-service and total times, though the reference code is somewhat less intense to perform for the typical group size of 6 patients represented.

The RUC also compared the survey code to CMS code G0109 *Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes* (work RVU = 0.25, intra-service time of 6 minutes and total time of 10 minutes), another time-based group service, which was valued based on a typical group size of 5 patients and is reported per 30 minutes instead of for the first hour of the group session (as is the case for the survey code). If G0109 was performed for 5 patients for a one hour session, the total aggregate work RVU would be 2.50; however, if the group size for G0109 was 6 patients for a one hour session, as is the case for the typical survey code, the total aggregate work RVU would be 3.00 for the reference. Group caregiver behavior management training is a somewhat more intense service to perform relative to diabetes management group training. Comparison to this reference code confirms that a value of 0.43 per patient for the survey code would not overvalue the typical physician or other QHP work. In addition, the RUC noted that unlike the reference code, which is reported in multiple units for the same patient, the survey code is structured as a base code; therefore, all the pre-service and post-service work for the entire session are included only in the base code. Also, although the median number of patients represented in a group is six, it is not uncommon for two parents/caregivers to attend a group session for the same patient for caregiver behavior management training. All else held equal, larger group sizes are somewhat more intense to lead. **The RUC recommends a work RVU of 0.43 for CPT code 96202.** The RUC noted that this recommendation is based on a median group size of six.

96203 ***Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)***

The RUC reviewed the survey results from 75 psychologists, child and adolescent psychiatrists, and dieticians with the understanding that the survey respondents were asked to evaluate the group service in total and not based on an individual group participant. Also, a custom survey question was added that asked respondents to provide the average number of patients that were represented at a typical caregiver behavior management group session. The question yielded a median response of six patients. The intent was to obtain per session data on the service, that could then be divided by the average number of patients to yield the per patient data. This methodology for surveying time-based group codes has recent precedent when it was relied on for group health behavior intervention codes 96164-96165; CMS accepted the HCPAC's recommendation in CY2020 rulemaking.

The specialty societies noted that although the median survey respondent has not performed this service in the past 12 months, likely due to the ongoing COVID-19 public health emergency, 2/3rds of the survey respondents have performed this service in the past 5 years and the other survey respondents were instructed to only complete the survey if they were at least sufficiently familiar with the service.

The RUC agreed that the median per session work value of 0.73 RVUs converted to the per patient work value of 0.12 work RVUs by dividing by the typical six patients would appropriately value this service. The RUC recommends 3 minutes of intra-service and total time for this group-based add-on service. These physician/QHP times were a result of converting the median group survey times of 15 minutes of intra-service time and converting it to per patient times and rounding to the nearest whole number. To justify a work value of 0.12 per patient (or 0.73 for the typical group), the RUC compared the survey code to CPT code 90840 *Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 1.50, intra-service time of 30 minutes) and noted that, relative to a typical group session for the survey code reported for the same length of 30 minutes, the reference code is assigned a higher work value of 1.50 versus 1.46 for two units of the add-on survey code for 6 patients. The RUC also compared the survey code to another time-based group code 96165 *Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.10, intra-service time of 10 minutes). CPT code 96165 was valued assuming a larger group size of 7 patients. Using both services assumed typical group sizes, the survey code would represent a total aggregate work value of 0.73 compared to 0.70 for the reference code. As the survey code is slightly more intense to perform, in part because the actual number of people in the room is often higher due to the two parents commonly representing a single patient for the survey code, assigning a slightly higher value to the survey code is warranted. **The RUC recommends a work RVU of 0.12 for CPT code 96203.** The RUC noted that this recommendation is based on a median group size of 6.

Relativity Assessment Workgroup Flag
The RUC recommends that the Relativity Assessment Workgroup review these services in three years (October 2024) to review whether assumption of a median group size of 6 patients remains appropriate.

Practice Expense
The Practice Expense (PE) Subcommittee agreed to recommend a new direct supply input for a binder with dividers and noted that it is typical to provide the parent(s)/caregiver(s) with a 3-ring binder at the first session to store materials throughout the duration of the 8 sessions and there is no existing supply item that appropriately captures this resource. The PE Subcommittee also confirmed that for SK114 *tissues (Kleenex)* the number of assigned tissues is appropriate (2 tissues per patient per session (2/144 of a box)). **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

<u>Emergency Department Services (Tab 12)</u>
Presenters: Jordan Celeste, MD (ACEP) and Steven Krug, MD (AAP)
Facilitation Committee #1

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits

3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel revised the five emergency department visit codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on medical decision making.

Compelling Evidence
RUC members expressed concern with comparing the specialty society proposed values with the 2021 CMS values which were increased by CMS prior to receiving any input from the RUC. Although the RUC recommendations below are budget neutral, if making no adjustments to utilization assumptions for these revised codes, the RUC had concurred that it would be beneficial for the societies to still present compelling evidence arguments. The specialty societies presented two points for compelling evidence that the work of providing emergency department services has changed. First, a flaw in the methodology used in the current valuation; and second, a change in technology due to the implementation and more recent changes to EHRs leading to an increase in workflow disruption and task switching for emergency department services.

Flaw in the Methodology Used in the Current Valuation
In 2021, the revisions and updated relative value units (RVUs) went into effect for E/M office visit codes (99202-99215). Concurrently, even though the emergency department Services were not revised for the CPT cycle or reviewed by the RUC for 2021, CMS decided to increase the RVUs of the emergency department services to remain either equal or slightly higher than the corresponding level of a new patient office visit codes. In February 2021, the CPT Editorial Panel revised the five emergency department visit codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on medical decision making. Hypothetically, had the 2020 valuation of emergency department services remained in effect for 2021, that would have resulted in a rank order anomaly between office visit services and emergency medicine services. The RUC noted that the level of decision making required for 99282-99285 mirrors the corresponding new patient office visit codes 99202-99215. However, the methodology employed by CMS did not rely on a standardized survey or a crosswalk methodology.

Change in Technology
According to National Medical Ambulatory Care Survey (NAMCS) data, in 2017, 90 percent of emergency physicians used electronic health records exclusively, 8 percent used them partially, and 2% used only paper records.[1] Relative to the 2016 data, which was not yet available when the emergency department services were reviewed by the RUC in 2018, the percentage of emergency physicians exclusively using electronic health records increased by 10 percent in only one year. Separately, in 2008, the corresponding numbers were 23 percent, 49 percent, and 28 percent. These differences demonstrate that the technology used to deliver emergency care has changed dramatically. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug interactions and, with increasing use of homeopathic substances, drug-substance interactions. The use of EHRs has increased physician work by increasing the time physicians spend documenting the medical record. The centralization of data is in the best interest of patients and will help support

[1] Rui P, Kang K. National Hospital Ambulatory Medical Care Survey: 2017 emergency department summary tables. National Center for Health Statistics. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf.

quality care; however, this centralization does increase the time that physicians spend reviewing patient information.

The specialties claimed that EHR adoption has led to a decrease in workflow efficiency. Emergency physician workflow has been particularly impacted by relatively more recent updates to EHR systems; these systems now generate large numbers of alerts for the provider to review. According to a recent study published in the Journal of Emergency Medicine on the impact of EMR alerts on emergency physician workflow, 78 percent of emergency department patient encounters involved alerts. 70 percent of that subset of patient encounters trigger multiple alerts. In addition, just 2 percent of these alerts result in a change in clinical management.[2] The specialties noted that this recent increase in workflow disruption and task switching for emergency department services has increased their intensity and complexity, the stress for providers and the risk for patients.

The RUC agrees that there is compelling evidence of 1) flaw in the methodology used in the current 2021 valuation of the services and 2) technology changes with the growth in use of EHRs and more recent changes to EHRs leading to an increase in workflow disruption and task switching for emergency department services.

Intra-service Only time on Date of Encounter
Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient. As was also done for the office visit services in 2019 and all other E/M services, all face-to-face and non-face-to-face physician or qualified healthcare professional (QHP) work on the date of the encounter was determined to be intra-service work and of the same intensity. In addition, as all the pre-service and post-service work for an emergency department visit would occur on the date of the encounter, all time is considered intra-time or total time. This is consistent with all inpatient and observation hospital codes, as the reporting of these inpatient services is based on total time on the date of encounter.

99281 ***Emergency department visit for the evaluation and management of a patient, that may not require the presence of a physician or other qualified health care professional***
The RUC reviewed the survey results from 158 emergency physicians, pediatricians and advanced practice nurses for the lowest level emergency department visit code, CPT code 99281, and determined that the survey median value of 0.25 work RVUs appropriately accounts for the physician work typically required to perform this service. The RUC recommended an intra-service and total time of 10 minutes for 99281, 3 minutes higher than the total time of reference 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. Usually, the presenting problem(s) are minimal* (work RVU= 0.18, total time of 7 minutes). The RUC noted that the survey code has a disparate typical patient that may require slightly more time than the typical patient for 99211.

To further support a value of 0.25, the RUC compared the survey code to MPC code 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*

[2] Todd B et al. Impact of Electronic Medical Record Alerts on Emergency Physician Workflow and Medical Management. J Emerg Med. 2021 Mar;60(3):390-395. doi: https://doi.org/10.1016/j.jemermed.2020.10.017. Epub 2020 Dec 6. PMID: 33298357.

(work RVU= 0.24, intra-service and total time of 7 minutes) and noted that the survey code typically involves 3 more minutes of intra-service and total time, supporting a value of 0.25 for the survey code. The RUC concluded that CPT code 99281 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 0.25 for CPT code 99281.**

99282 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making***
The RUC reviewed the survey results from 162 emergency medicine physicians, pediatricians and advanced practice nurses and determined that a value between the survey 25th percentile of 0.80 and survey median of 0.99 work RVUs would appropriately account for the work required to perform this service. Therefore, the RUC recommends crosswalking CPT code 99282 to top key reference service code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU= 0.93, total time of 20 minutes). The RUC noted that this value is also the current CMS value. The RUC recommends 18 minutes of intra-service and total time, as supported by the survey. Although, both services involve straightforward medical decision making and would be assigned the same absolute work value, the emergency department service requires a higher work intensity due to the service typically involving somewhat less time. The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress.

For additional support, the RUC compared the survey code to CPT code 73700 *Computed tomography, lower extremity; without contrast material* (work RVU= 1.00, total time of 20 minutes) and noted that the survey code typically involves slightly less time and slightly less physician work. The RUC concluded that CPT code 99282 should be valued based on a direct work RVU crosswalk to CPT code 99202 which falls between the survey median and 25th percentile. **The RUC recommends a work RVU of 0.93 for CPT code 99282.**

99283 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making***
The RUC reviewed the survey results from 163 emergency medicine physicians, pediatricians and advanced practice nurses and determined that a value between the survey 25th percentile of 1.50 and survey median of 1.75 would appropriately account for the work required to perform this service. Therefore, the RUC recommends a direct work RVU crosswalk for CPT code 99283 to top key reference service code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU= 1.60, total time of 35 minutes). The RUC noted that this value is also the current CMS value. The RUC recommends 30 minutes of intra-service and total time. Although, both services involve a low level of medical decision making and would be assigned the same absolute work value, the emergency department service requires a higher work intensity due to the service typically involving somewhat less time. The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress.

For additional support, the RUC also compared the survey code to MPC code 78072 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization* (work RVU= 1.60, total time of 30 minutes) and noted that both services involve the same amount of total time and a similar amount of physician work. The RUC concluded that CPT code 99283 should be valued based on a direct work RVU crosswalk to CPT code 99203 which falls between the survey median and 25th percentile. **The RUC recommends a work RVU of 1.60 for CPT code 99283.**

99284 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making***
The RUC reviewed the survey results from 163 emergency medicine physicians, pediatricians and advanced practice nurses and determined that the survey median overestimated the work typically required to perform this service. After thorough discussion, the RUC recommends the survey 25th percentile work RVU of 2.60 for CPT code 99284 which is also the same work value as top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes). The RUC recommends 40 minutes of intra-service and total time as supported by the survey. The RUC compared the survey code to top key reference code 99204 and noted that, although it concurs with the presenting specialties that 99284 is a more intense service to perform, 99204 typically involves 20 more minutes of total time. Although both services involve moderate medical decision making and would be assigned the same absolute work value, the emergency department service requires a higher work intensity due to the service typically involving less time. The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress. The RUC concluded that CPT code 99284 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.60 for CPT code 99284.**

99285 ***Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making***
The RUC reviewed the survey results for 162 emergency medicine physicians, pediatricians and advanced practice nurses for the highest level emergency department visit code, CPT code 99285, and determined that the survey median value of 4.00 appropriately accounts for the physician work required to perform this service. The RUC noted that this value is also the current CMS value. The RUC recommends 60 minutes of intra-service and total time, 5 minutes more than the current time assigned to this service. The RUC noted that a work value of 4.00 would appropriately assign 99285 a work value that reflects an intensity higher than 99284. The RUC compared the survey code to critical care visits 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes) and add-on 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, total time of 30 minutes) and noted that a value of 4.00 for the highest level ED visit code maintains appropriate relativity with critical care services. The RUC also compared the survey code to top key reference service code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU=3.50, total time of 88 minutes) and noted that although both services involve a high level of medical decision making and the reference code involves more total

time, it is appropriate to assign the highest level ED visit code a higher work value. 76 percent of the survey respondents that selected 99205 as their top key reference service had indicated that a level 5 emergency department visit is more intense and complex to perform (with another 11 percent rating 99285 as somewhat more intense/complex). The acute and unscheduled care of multiple undifferentiated patients simultaneously make emergency department services relatively more intense and complex to perform relative to the analogous level of a new patient office visit. The physician/QHP has little to no control over incoming volume or workflow which increases psychological stress. The RUC concluded that CPT code 99285 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 4.00 for CPT code 99285.**

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

Practice Expense
No direct practice expense inputs are recommended for CPT codes 99281-99285 as they are facility-only services.

Nursing Facility Services (Tab 13)
Presenters: Audrey Chun, MD (AGS), Brooke Bisbee, DPM (APMA), Carlo Milani, MD (AAPMR) and Charles Crecelius, MD, PhD (AMDA)

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted the annual nursing facility assessment code and revised seven nursing facility codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of a nursing facility visit service code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The nursing facility services were surveyed for the April 2021 RUC meeting. The survey time captured includes pre-service time 1-day before the date of encounter, intra-service time is all the time on the date of encounter and post-service time is 3-days after the date of encounter.

The RUC noted that all the of these services are typically performed in the skilled nursing facility which requires a higher level of care than the nursing facility.

COMPELLING EVIDENCE

In April 2021, the RUC met to review the nursing facility changes. The specialty societies indicated that there is compelling evidence based on flawed methodology. The specialty societies reviewed the methodology used by the RUC in 2007 to arrive at the current values. That methodology was inconsistent among the codes in the family and was not based on survey values or direct crosswalks. For example, 99304, the initial nursing visit code requiring low level medical decision making was valued based on the sum of the value of 99203, a new patient visit also requiring a low level of medical decision making, plus one-fourth the value of 99374, physician supervision of a patient under the care of a home health agency. The RUC justified its recommendations for all the initial nursing visit codes by dividing the median time of the nursing visit code by the median time of the comparable subsequent hospital visit code, multiplying that fraction by the work RVU of the hospital visit code and adding one-fourth of 99374. Similarly, the methodology for valuing the subsequent nursing visit codes was inconsistent and differed from the methodology used for the initial visit codes. The RUC agreed that there is compelling evidence that the previous valuation was based on flawed methodology.

INITIAL NURSING FACILITY CARE

99304 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.***
The RUC reviewed the survey results from 203 physicians and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 6 minutes of pre-service time, 25 minutes of intra-service time and 5 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60, 25 minutes intra-service time and 35 minutes total time) and determined that 99304 describing straightforward/low medical decision-making is appropriately slightly less physician work than CPT code 99203.

The RUC also compared 99304 to the second top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 15 minutes intra-service time and 20 minutes total time) and determined that CPT code 99304 requires much more physician work and time, thus is valued appropriately. The survey supports a value between the two new patient office visits and the RUC agrees CPT code 99304 is in the proper rank order among other similar services.

For additional support, the RUC referenced MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes of intra-service time) and

code 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46 and 20 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.50 for CPT code 99304.**

99305 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.***
The RUC reviewed the survey results from 204 physicians and determined that the survey 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service time, 35 minutes of intra-service time and 10 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60, 40 minutes intra-service time and 60 minutes total time) and determined that 99305 requires slightly less physician work and time to perform.

The RUC also compared 99305 to the second top key reference service, 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 25 minutes intra-service time and 35 minutes total time) and determined that 99305 requires much more physician work and time than 99203. The survey supports a value between the two new patient office visits and the RUC agrees CPT code 99305 is in the proper rank order among other similar services.

For additional support, the RUC referenced MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes of intra-service time) and code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU = 2.40 and 30 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 2.50 for CPT code 99305.**

99306 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 208 physicians and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of pre-service time, 50 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU =

3.50, 59 minutes intra-service time and 88 minutes total time) and determined that these services require the same physician work and should be valued the same. Although 99306 requires slightly less physician time, both require a high level of medical decision making and similar typical patients who require intensive management.

For additional support, the RUC referenced MPC code 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month* (work RVU = 3.57 and 70 minutes of intra-service/total time) and code 50328 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each* (work RVU = 3.50 and 45 minutes of intra-service/total time), which require similar physician work and time. **The RUC recommends a work RVU of 3.50 for CPT code 99306.**

SUBSEQUENT NURSING FACILITY CARE

99307 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.***
The RUC reviewed the survey results from 196 physicians and determined that the survey 25th percentile work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 1 minutes of pre-service time, 12 minutes of intra-service time and 1 minute of post-service time.

The RUC compared the surveyed code to the top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) and determined that these services require the same straightforward level of medical decision making, the same physician work and similar physician time to perform, thus should be valued the same.

The RUC also compared 99307 to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 20 minutes intra-service time and 40 minutes total time) and determined that 99307 requires much less physician work, time and a lower level of medical decision making, thus is valued appropriately.

For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 15 minutes of intra-service time) and code 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 15 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 0.70 for CPT code 99307.**

99308 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***
The RUC reviewed the survey results from 214 physicians and determined that the survey 25th percentile work RVU of 1.30 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes of pre-service time, 18 minutes of intra-service time and 4 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 20 minutes intra-service time and 40 minutes total time) and determined that these services require the same low level of medical decision making, the same physician work and similar physician time to perform.

The RUC also compared 99308 to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and determined that 99308 requires less physician work, time and level of medical decision making to perform than 99214, thus is valued appropriately.

For additional support, the RUC referenced MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes of intra-service time) and code 74280 *Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered* (work RVU = 1.26 and 20 minutes of intra-service time), which require similar physician work and time.
The RUC recommends a work RVU of 1.30 for CPT code 99308.

99309 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC reviewed the survey results from 217 physicians and determined that the 25th percentile work RVU of 1.92 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of pre-service time, 30 minutes of intra-service time and 10 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and determined that these services require the same moderate level of medical decision making, physician work and physician time to perform.

The RUC also compared 99309 to the second top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter* (work RVU = 2.80, 45 minutes intra-service time and 70 minutes total time) and determined that 99309 requires less physician work, time and level of decision making, thus is valued appropriately.

For additional support, the RUC referenced MPC code 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99 and 30 minutes of intra-service time) and code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (work RVU = 1.98 and 30 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.92 for CPT code 99309.**

99310 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 203 physicians and determined that the survey 25th percentile work RVU of 2.80 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service time, 45 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter* (work RVU = 2.80, 45 minutes intra-service time and 70 minutes total time) and determined that these services require the same high level of medical decision making, physician work and physician time to perform, thus should be valued the same.

The RUC also compared 99310 to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50, 40 minutes intra-service time and 70 minutes total time) and determined 99310 requires less physician work and the typical patient is less intense than the critical care service. Thus, CPT code 99310 is appropriately valued lower than 99291.

For additional support, the RUC referenced MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60 and 40 minutes of intra-service time) and code 75561 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;* (work RVU = 2.60 and 45 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 2.80 for CPT code 99310.**

NURSING FACILITY CARE DISCHARGE DAY MANAGEMENT

99315 ***Nursing facility discharge day management; 30 minutes or less***
99316 ***Nursing facility discharge day management; more than 30 minutes***
The RUC reviewed CPT codes 99315 and 99316 and determined to maintain the proper rank order,

these services should be reviewed with the hospital discharge day management codes, 99238 and 99239, in October 2021**. The RUC recommends to table review of CPT codes 99315 and 99316 until October 2021.**

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

CPT Code		Time on the Date of Encounter Recommendation to CPT
99304	Initial nursing facility care, per day, straightforward or low MDM	**25**
99305	Initial nursing facility care, per day, moderate MDM	**35**
99306	Initial nursing facility care, per day, high MDM	**45**
99307	Subsequent nursing facility care, per day, straightforward MDM	**10**
99308	Subsequent nursing facility care, per day, low MDM	**15**
99309	Subsequent nursing facility care, per day, moderate MDM	**30**
99310	Subsequent nursing facility care, per day, high MDM	**45**

Practice Expense
The Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

<u>Home and Residence Services (Tab 14)</u>
Presenters: Brooke Bisbee, DPM (APMA) and Audrey Chun, MD (AGS)

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted twelve of the domiciliary, rest home (e.g., boarding home) and custodial care services to merge these services with the home visit services. The eight revised codes describe home and residence services to align with the principles included in the office or other outpatient E/M office visits by documenting and selecting level of service based on total time or medical decision making.

In April 2021, the specialty societies surveyed the eight home and residence codes but did not obtain the required number of survey responses for the established patients (99347, 99348, 99349 and 99350). More importantly, responses from the predominant provider, such as nurse practitioners, for some of the services was not achieved (99344, 99345, 99349 and 99350). The specialty societies intend to work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify qualified healthcare professionals, focusing on nurse practitioners, who predominantly perform home visit services and match them with societies to survey those individuals. The specialty societies also would like to ask the Research Subcommittee if it would be possible to limit the additional surveys to focus on obtaining valid responses and from the predominant providers (99344-99450).

The RUC recommends that the home and residence services be postponed until October 2021, and the specialty societies work with the Research Subcommittee to obtain valid and representative responses.

Prolonged Services – Clinical Staff Services (PE Only) (Tab 15)
Presenters: Elizabeth Blanchard, MD (ASCO), Audrey Chun, MD (AGS), Steven Krug, MD (AAP), Katina Nicolocakis, MD (ATS) and Michael Perskin, MD (AGS)

In May 2014, the CPT Editorial Panel established two new add-on codes to describe prolonged office observation in conjunction with an evaluation and management (E/M) service, specifically to address additional clinical staff resources in the office or outpatient setting. CPT code 99415 was created to describe the first hour of prolonged clinical staff services provided in addition to an office E/M visit, while CPT code 99416 was created to describe each additional 30 minutes beyond that first hour of prolonged clinical staff service time that was provided in addition to the office E/M. CPT codes 99415 and 99416 are now under consideration by the RUC and Practice Expense (PE) Subcommittee due to the recent changes by the Panel to the prolonged services family code set.

As part of its deliberations, the PE Subcommittee first reviewed and concurred that there is compelling evidence to support an increase in the clinical staff time based on flawed methodology. When the RUC initially valued these add-on codes in September 2014, they assumed a one clinical staff to four patient ratio for these services. Meaning that the clinical staff time was divided among four patients due to anticipated multi-tasking. For 99415, 60 minutes was divided by four patients, hence 15 minutes each. Similarly, the clinical staff time that was included in the original recommendation for 99416 was reached by dividing four patients by 30 minutes for roughly 8 minutes of time. However, since the RUC's original valuation in 2014, changes to CPT language have specifically clarified that the time reported for these codes are for a single patient. This is contradictory to the 1:4 multi-tasking ratio used by the RUC to value these codes and as such, the specialties presented compelling evidence based on flawed methodology which passed unanimously.

The PE Subcommittee thoroughly reviewed the practice expense recommendations for these two codes and approved the inputs with no modifications. The PE Subcommittee noted that the 30 minutes of clinical staff time for 99415 and the 15 minutes for 99416 were appropriately shifted from CA020 *Assist physician or other qualified healthcare professional---directly related to physician work time (other%)* to CA021 *Perform procedure/service---NOT directly related to physician work time.* There

are no additional clinical activities recommended and no medical supply inputs. There are only two equipment items, EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *table, exam*, which were deemed appropriate as they are standard inputs for use in the physician office setting.

The PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued. **The RUC recommends the direct practice expense inputs as submitted by the specialty society for CPT codes 99415 and 99416.**

RUC Referral to CPT
The PE Subcommittee asked for additional clarification about how these time-based codes will be tracked and whether these services are required to be provided face-to-face. There was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state "direct patient contact with physician supervision;" while the preparatory paragraph for these codes describes "face-to-face time." Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language.

Cognitive Assessment and Care Plan Services (Tab 16)
Presenters: Audrey Chun, MD (AGS), Katherine Coerver, MD (AAN) and Kevin Kerber, MD (AAN)

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel revised code 99483 to replace "50 minutes" from its descriptor with "XX minutes of total time is spent on the date of the encounter", as determined by the RUC survey, to align with the principles included in the E/M office visits.

Due to the increase in office visits for 2021, CMS finalized a proposal to increase CPT code 99483 from 3.44 to 3.80 work RVUs. CMS indicated that 99483 includes an evaluation of a patient's cognitive functioning and requires collecting pertinent history and current cognitive status, all of which require medical decision making of moderate or high complexity. To not create a rank order anomaly with 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU = 3.50), CMS increased 99483 by using the ratio of the increase

between the CY 2020 and CY 2021 values for 99205 to commensurate with the increase to CPT code 99205.

99483 ***Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:***

- **Cognition-focused evaluation including a pertinent history and examination,**
- **Medical decision making of moderate or high complexity,**
- **Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity,**
- **Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]),**
- **Medication reconciliation and review for high-risk medications,**
- **Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s),**
- **Evaluation of safety (eg, home), including motor vehicle operation,**
- **Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks,**
- **Development, updating or revision, or review of an Advance Care Plan,**
- **Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.**
  Typically, 60 minutes of total time is spent on the date of the encounter.

The RUC reviewed the survey results from 74 neurologists, geriatricians and internal medicine physicians and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 11 minutes of pre-service time, 60 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU = 3.50, 59 minutes intra-service time and 88 minutes total time) and determined the surveyed code is appropriately valued the same because the vignette for 99205 describes *a new patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function*, which is an extremely intense patient. The RUC did not believe that the typical patient for 99483, *a patient with hypertension, diabetes, arthritis, and coronary artery, disease presents with confusion, weight loss, and failure to maintain her house, where she lives alone*, is more intense. Additionally, the medical decision making (MDM) for CPT code 99205 is at a high level, whereas for CPT code 99483 the MDM is at a moderate/high level of complexity. Lastly, the physician time required for these services is almost identical, 86 minutes (99483) and 88 minutes (99205) total time. Therefore, the RUC determined 99483 should be valued the same as 99205.

The RUC compared 99483 to the second top key reference service 90792 *Psychiatric diagnostic evaluation with medical services* (work RVU = 4.16, 60 minutes intra-service time and 90 minutes total time) and determined that the surveyed code requires less physician time and work and thus is appropriately valued lower.

For additional support, the RUC referenced MPC code 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month* (work RVU = 3.57 and 70 minutes intra-service and total time). The RUC concluded that CPT code 99483 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.50 for CPT code 99483.**

CPT Descriptor Time
The RUC recommends that the CPT Editorial Panel insert the "60 minutes of total time is spent on the date of the encounter" based on the survey median.

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs as submitted by the specialty societies and modified the clinical staff time, moving 6 minutes of CA006 *Confirm availability of prior images/studies* to CA048 *Identify need for imaging, lab or other test result(s) and ensure information has been obtained - three days prior (to be used with E/M only).* The specialty societies consolidated and reduced the clinical staff time for CA021 *Perform procedure/service--- NOT directly related to physician work time* to 45 minutes, as outlined in the PE summary of recommendation (SOR) form. The PE Subcommittee adjusted the equipment calculation to the default formula for EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *table, exam*. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

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

XI. CMS Request/Relativity Assessment Identified Codes

Insertion of Spinal Stability Distractive Device (Tab 17)
Presenters: Damean Freas, MD (NANS), Michael Lubrano, MD (ASIPP), Kano Mayer, MD (NASS), David Reese, MD (AAPMR), Richard Rosenquist, MD (ASA) and Karin Swartz, MD (AAHKS)

In July 2020, the Relativity Assessment Workgroup reviewed an action plan for 22867 and 22868 and recommended to remove them from new technology list because there was no demonstrated technology diffusion that impacts work or practice expense. The primary performers of these services did not comment on 22869/22870, as those services are typically performed by other providers. The Workgroup requested an action plan from the primary performers of code 22869 and 22870 (interventional pain management, pain management, anesthesiology and physical medicine and rehabilitation) for review. In December 2020, the Relativity Assessment Workgroup noted that these services are now performed predominantly by a specialty(s) other than the specialty(s) that initially surveyed making the review for new technology difficult to assess. The RUC recommended that CPT codes 22869 and 22870 be surveyed for the April 2021 RUC meeting.

22869 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level***
The RUC reviewed the survey results from 75 physicians and determined that a value between the survey 25th percentile of 6.75 and survey median of 8.00 would most accurately reflect the typical physician work necessary to perform this service. Therefore, the RUC recommends maintaining the current work value for this service of 7.03. The RUC recommends 33 minutes of pre-service evaluation, 12 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 17 minutes of immediate post-service time, a ½ 99238 discharge visit, 1-99213 and 1-99212 post-operative office visits. The specialties noted that the current work for the procedure, as well as the typical patient, has not changed since the previous survey in 2016, only the dominant specialty has changed from surgeon to anesthesiologist and pain physician.

To justify a value of 7.03, the RUC compared 22869 to CPT code 22511 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral* (work RVU= 7.33, intra-service time of 45 minutes, total time of 150 minutes) and noted that both services have identical intra-service times, though the survey code involves more total time. The RUC also compared the survey code to 2nd key reference code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU= 7.39, intra-service time of 45 minutes, total time of 199 minutes) and noted that both services are typically outpatient, involve an identical amount of intra-service time and a similar overall amount of physician work. The RUC concluded that the value of CPT code 22869 should be maintained at 7.03 work RVUs, between the 25th percentile and median of the survey. **The RUC recommends a work RVU of 7.03 for CPT code 22869.**

22870 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 75 physicians and concurred that maintaining the current work value of 2.34 appropriately accounts for the work required to perform this service and is substantially below the survey 25th percentile. The RUC noted that the survey 25th percentile work value of 3.63 supports this recommendation. The RUC recommends 45 minutes of intra-service time for this add-on code.

The RUC compared the survey code to CPT code 15772 *Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service and total time of 45 minutes) and noted that both add-on services involve the same amount of time to perform. The RUC also compared the survey code to CPT code 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU= 2.38, intra-service and total time of 45 minutes), which also requires the same amount of physician time to further support a value of 2.34 for the survey code. The RUC concluded that the current value of CPT code 22870, which falls below the 25th percentile of the survey, should be maintained. **The RUC recommends a work RVU of 2.34 for CPT code 22870.**

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

RUC Database Flag
The RUC noted that CPT code 22870 should be flagged as "Do not use to validate for physician work."

Knee Arthroplasty (Tab 18)
Presenters: William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS) and Adolph Yates, MD (AAHKS)

In October 2020, the Relativity Assessment Workgroup identified CPT code 27446 with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management (E/M) services within the global period and 2019e Medicare utilization over 10,000. The Workgroup concluded that CPT code 27446 represents a site of service anomaly since visits are currently included in the valuation of this service that are not typically occurring. The RUC recommended that CPT code 27446 be surveyed for January 2021 with the appropriate code family. At the January 2021 meeting, the specialty societies submitted a request to defer survey until April 2021 due to logistical reasons including timing and a desire to be placed on the Research Subcommittee agenda "to review a proposed revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work." The RUC recommended that CPT code 27446 be surveyed for April 2021 with the appropriate code family.

Pre-Service Work
In October 2019 during review of CPT code 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)*, the specialties noted that considerable work by the clinical staff, surgeons, and qualified healthcare providers (QHPs) is required to facilitate, coordinate, validate and document the assessment and optimization of patients prior to total joint replacement surgery. The service has also evolved in that patients are more frequently discharged home rather than to inpatient rehabilitation or skilled nursing facilities. This deliberate reduction in post-acute care service requires considerable work by the surgeon and QHPs prior to surgery.

The RUC agreed that the pre-service planning activities are being performed on a routine basis for the typical patient; however, the 090-day global period structure does not allow inclusion of this work. In addition, the current code does not include this additional work in the descriptor. The RUC discussed options on how to capture these pre-service activities performed by the physician or QHP. The RUC indicated that separate planning codes may be developed, or current codes such as the prolonged service codes may be reported for these activities. It was recognized that such codes are intended to capture a single episode of time and that the added work in the preoperative period does not occur in such units of time (e.g., 30 minutes in one session as opposed to over the course of a few days/calls).

The RUC affirmed the October 2019 recommendation for CPT code 27447 and noted that the pre-service time discussion also applies to family code 27446. The RUC recommends that the specialty, and other interested parties, consider developing a CPT coding application to address this preoperative period issue.

27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment*
The RUC reviewed the survey results from 126 orthopaedic and hip/knee surgeons and concurred that the survey median (19.60) and 25th percentile (18.60) work RVU overvalued the physician work for this service. Therefore, the RUC determined that a direct work RVU crosswalk to CPT code 67108 *Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique* (work RVU= 17.13, 90 minutes intra-service time and 295 minutes total time) appropriately accounts for relative physician work. The crosswalk code was surveyed in 2015 and has identical intra-service time as 27446 and similar total time and intensity. The RUC notes that the crosswalk value of 17.13 work RVUs includes three key

considerations: no change in intraoperative time, one day less of hospital E/M work, and an increase in level of postoperative office work.

The RUC recommends the following physician time components: 40 minutes pre-service evaluation, 15 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, and 45 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 and 1-99214 office visits, 310 minutes total time. Pre-service time package 4 is recommended with an increase of 12 minutes to positioning time (total = 15 minutes) to account for assisting with appropriately positioning the patient, padding bony prominences, and applying thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; placing the patient's leg properly on the table and positioning with proper bolstering to aid surgical exposure; placing a tourniquet on the proximal thigh; confirming tourniquet settings and validating function. This is consistent with both the survey median and historical RUC precedent for many similar orthopaedic extremity surgical codes. In addition, the package time for scrub/dress/wait was reduced to 15 minutes to be consistent with the survey median.

The RUC discussed the CMS 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy as it relates to the post-service time for the survey code. This policy excludes inclusion of inpatient visit codes in the global payment for services that are typically reported as outpatient services. CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as 23-hour stay outpatient services. In the CY2011 Final Rule, CMS finalized a policy to no longer allow codes with outpatient claims status to include bundled subsequent inpatient hospital visits (eg 99231-99233) into the surgical global payment. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. For code 27446, per the CMS policy, the intra-service time is reallocated from the same-day E/M code 99232 to the immediate post-service time of the outpatient service (adding 20 minutes of intra-service time from 99232). Though the median survey immediate post-service time was 25 minutes, the CMS 23-hour stay policy was applied resulting in 45 total post-service minutes. The RUC recommends post-service time package 9b and, following the CMS 23-hour policy, the E/M same day visit is not shown and instead the intra-service time of 20 minutes has been added to the median survey post time of 25 minutes (total=45 minutes). In addition, following the CMS 23-hour policy, the next day final evaluation of the patient and discharge management work is indicated as a discounted 0.5 x 99238 – or one-half of an E/M service (0.64 RVUs; 19 min).

For the post-service office visits, the RUC recommends the survey median response of three total office visits: 1-99214 and 2-99213. The first office visit is typically at 2 weeks following surgery; both the estimated total time and medical decision-making support 99214. The subsequent office visits are typically at 6 weeks and 10 weeks after surgery; both the estimated total time and medical decision-making support 99213 for both visits. Discussion around the 99214-visit clarified that there is management of medication, particularly at that first visit when there is often increased pain that necessitates an opioid adjustment and justifies the level 4 office visit.

To justify the crosswalk value of 17.13 work RVUs, the RUC compared the survey code to the key reference service codes 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* (work RVU = 19.60, 100 minutes intra-service time and 377 minutes total time) and 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU = 22.13, 140 minutes intra-service time and 448 minutes total time) and noted that the physician work and intra-service and total time of the survey code are lower than the two reference services while the intensity of the survey code is slightly higher than either reference service. The RUC further noted that the CMS 23-

hour policy impacts the intensity of work per unit time and may falsely elevate the IWPUT because, if the recommendation included the full discharge day visit time of 38 minutes rather than 19 minutes (0.5- 99238) and if the 99232 hospital visit remained at the full time (40 minutes), rather than adding only 20 minutes to the immediate post service time, the total time would have been 349 minutes (similar to current value of 345), with a final IWPUT of 0.101 and WPUT of 0.049, both of which are below the current values.

In addition to the comparison to total hip arthroplasty, the RUC also compared CPT code 27446 to CPT code 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 19.60, 97 minutes intra-service time and 374 minutes total time) which was recently approved by the RUC in October 2019 and re-affirmed at this meeting. The RUC noted that a value below 17.13 RVUs would create a rank order anomaly between 27446 unicompartmental knee arthroplasty (UKA) and 27447 total knee replacement (TKA). Below is a comparison of CPT codes 27446 to 27447:

	27446 (UKA)	**27447 (THA)**
Work RVU	17.13	19.60
Pre-time	70	70
Intra-time	90	97
Post-time	150	207
Total time	310	374
IWPUT	0.119	0.112
WPUT	0.055	0.052

The RUC agreed that UKA is more complex and intense than TKA for several reasons:

1. UKA is less common than TKA; default is total knee, while preserving natural structure with a partial knee when appropriate is more complex.
2. UKA has higher failure and revision rate compared to TKA (~ 2X) requiring more complex considerations for repair.
3. Smaller incisions are employed to limit injury to the quadriceps mechanism, but must still allow visualization of the other compartments to assess articular cartilage damage (which might preclude UKA and require TKA).
4. The cruciate ligaments (ACL and PCL) are retained, compared to TKA where the ACL +/- PCL are resected; this makes exposure and stability/balancing more difficult.
5. Although basic alignment devices and cutting guides are used for the bone resection, like TKA, free-hand refinements and/or use of additional technology (e.g., computer-aided, robotic assisted) that add complexity to the procedure are typically employed.
6. In a TKA, the entire articular surface of both tibia and femur are resected and replaced; in a UKA, only part of the joint is resected and replaced; alignment of the prosthetic surface with the native articular cartilage is required which adds complexity.

For additional support, the RUC compared CPT code 27446 to MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time and 283 minutes total time) and 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.75, 103 minutes intra-service time and 337 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation. The RUC concluded that CPT code 27446 should be valued based on a direct work RVU crosswalk to CPT code 67108 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 17.13 for CPT code 27446.**

Affirm RUC Recommendations
The RUC affirms its October 2019 work RVU recommendation of 19.60 for CPT code 27447.

Office Visits Included in Codes with a Surgical Global Period
The RUC strongly believes that it is appropriate to apply the increased valuation of the office visits to the visits incorporated in the surgical global packages. The RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard. The RUC urges CMS to apply the 2021 office visit increases to the office visits included in surgical global payment, as it has done historically.

Practice Expense
The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that the clinical work involved in the service had changed. Based on acceptance of compelling evidence, the PE Subcommittee carefully considered the clinical staff activities and discussed the specialty society recommendation of an additional 15 minutes for CA002 *Coordinate pre-surgery services (including test results)* and CA004 *Provide pre-service education/obtain consent*. The PE Subcommittee noted that the standard pre-service time package is 60 minutes for 090-day global period services and questioned the justification for the additional preclinical time. After thorough discussion, the PE Subcommittee reduced the recommendation to the standard 090-day pre-service clinical staff times for CPT code 27446 and affirmed the standard times for 27447. The PE Subcommittee with guidance from the CPT Editorial Panel representative also provided some potential options for the specialties to consider capturing any additional preclinical staff time, including possibly using existing codes including the 99415 prolonged services clinical staff code (under consideration at this meeting) or alternatively, generating a new CPT code description to truly capture the additional work. **The RUC recommends the direct practice expense inputs for CPT code 27446 as modified by the PE Subcommittee**.

The Practice Expense Subcommittee reviewed and affirmed the direct practice inputs for CPT code 27447 from October 2019 without modification. **The RUC recommends the direct practice expense inputs for CPT code 27447 as affirmed by the Practice Expense Subcommittee.**

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

Immunization Administration (Tab 19)
Presenters: Megan Adamson MD (AAFP), Suzanne Berman, MD (AAP), Jon Hathaway, MD (ACOG) and Steven Krug, MD (AAP)
Facilitation Committee #1

After considering public comments to the Proposed Rule for the CY 2021 Medicare Physician Payment Schedule, CMS did not finalize the proposal to crosswalk the valuation of CPT codes 90460, 90471, 90473 and HCPCS codes G0008, G0009, and G0010 to CPT code 36000 *Introduction of needle or intracatheter, vein* (work RVU = 0.18). CMS instead finalized a policy to maintain the CY 2019 payment for nine of the services in the immunization administration family, including the add-on codes. Maintaining the CY 2019 rates for these services also maintained the historical relationship between the base administration codes and the add-on CPT codes 90461, 90472, and 90474, instead of the proposal to value the add-on codes at 50 percent of the base codes. As previously discussed in the Proposed Rule, CMS approximated a cost for these services, but acknowledged the concerns that were raised in the public rulemaking comments received and will continue to seek additional information that specifically reflects the resource costs and inputs that

should be considered to establish payment for these services on a long-term basis. CMS welcomes the results of an updated formal review of these services as well as any additional information that may be helpful for valuation in the immediate future. Based on CMS' comments, the RUC reviewed these services at the April 2021 RUC meeting.

Compelling Evidence
The specialties provided compelling evidence that the current values for these services were derived via flawed methodology. The pediatric immunization administration codes, 90460 and 90461, were developed to promote physician counseling of hesitant parents and use of combination vaccines to address decline in national immunization rates and subsequently valued by the RUC in October 2009. However, in the 2011 Medicare Physician Payment Schedule, CMS did not accept the RUC recommendations for 90460 and 90461. Instead, CMS applied the same methodology used for the existing immunization administration codes (90471-90474) to establish the values for 90460 and 90461. CMS valued codes 90471 and 90473 (base) codes by hard coding them to code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* and then setting the RVUs for the add-on codes (90472 and 90474) at approximately half the value of the base codes. While the CMS values in and of themselves do not create flawed methodology, the process associated with valuing these codes is flawed for several reasons.

In contrast from how the RUC uses crosswalks to recommend a one-time value for a service for physician work, CMS hard-coded the physician work, PE and PLI RVUs for 90460 to 96372. As a result, when PE inputs for code 96372 were subsequently reduced by the RUC in January 2017, CMS automatically reduced the PE values for 90460 even though the same reductions in clinical staff time did not pertain to 90460. These reductions threatened the US national vaccination program by reducing the value below the Medicaid minimum payment rate for immunization administration. The specialties then began working with CMS to identify an alternative crosswalk methodology to reflect the physician counseling work and practice expense inherent in the service.

As noted above, code 96372 was the same code used by CMS years earlier to value immunization administration code 90471. Both 96372 and 90471 describe the physician work of direct supervision whereas 90460 and 90461 describe a more intense level of physician work involving patient counseling.

In addition to flawed methodology, there is a change in the patient population reflecting growing vaccine hesitancy. Although coverage levels for most childhood vaccines remain relatively high in the United States, numerous studies have documented that vaccine-related confidence has been decreasing among US parents over the past several years[3]. In 2011, only one in five physicians reported that a significant percentage of parents asked to spread out vaccines in a typical month. By 2014, that percentage had grown to 58% of respondents who reported frequent requests for alternative vaccination schedules[4]. Because altered vaccine schedules are associated with reduced vaccine rates and increase in vaccine administration errors, physician counseling is required to confront requests for alternative scheduling. **The RUC agreed that there is compelling evidence that the physician work has changed for these services due to flawed methodology in the recent CMS valuation and the patient population has changed.**

[3] https://www.tandfonline.com/doi/full/10.4161/hv.25085
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7242184/

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***

The RUC reviewed the survey results from 94 physicians and nurse practitioners and determined that the 25th percentile work RVU of 0.24 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service time as supported by the survey. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from that which is included in the E/M visit.

The pediatric immunization administration codes, 90460 and 90461, require more physician work than the adult immunization administration codes 90471-90474, because they require physician/qualified health care professional counseling. Counseling is typically provided with the adult codes, but it is not required. Secondly, as indicated in the compelling evidence statement, there has been an increase in vaccination hesitancy, which requires counseling with the parents by reviewing a 5-page vaccination information sheet (VIS), discussing the safety, efficacy and health benefits of the vaccinations.

The specialty societies indicated that CPT code 90460 requires slightly more work and is more intense than the recent COVID-19 immunization administration services (work RVU = 0.20 and 7 minutes intra-service time). There are currently four COVID-19 vaccinations in the market, whereas there are approximately 30 different preparations of childhood vaccines on the market. Due to concerns that are often product specific, it increases the intensity and the breadth of the discussion/counseling with the parent for CPT codes 90460 and 90461.

The RUC compared the surveyed code to the top key reference service 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU = 0.24 and 7 minutes intra-service time) and determined that these services both involve counseling on health risks for patients, require the exact same physician work and time, and therefore should be valued the same.

The RUC also compared 90460 to the second top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) and determined 90460 requires much less physician work and time to perform, thus is appropriately valued lower.

For additional support, the RUC referenced MPC codes 74019 *Radiologic examination, abdomen; 2 views* (work RVU = 0.23, 4 minutes of intra-service time and 6 minutes total time) and 93922 *Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)* (work RVU = 0.25, 5 minutes of intra-service time and 10 minutes of total time), which require similar physician work and time. The RUC concluded that CPT code 90460 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.24 for CPT code 90460.**

90461 ***Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 91 physicians and nurse practitioners and determined that the 25th percentile work RVU of 0.18 appropriately accounts for the work required to perform this add-on service. The RUC recommends 5 minutes of intra-service time as supported by the survey. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

The pediatric immunization administration codes, 90460 and 90461, require more physician work than the adult immunization administration codes 90471-90474, because they require physician/qualified health care professional counseling. Counseling is typically provided with the adult codes, but it is not required. Secondly, as indicated in the compelling evidence statement, there has been an increase in vaccination hesitancy, which requires counseling with the parents by reviewing a 5-page VIS, discussing the safety, efficacy and health benefits of the vaccinations.

The RUC compared the surveyed code to the top key reference service 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.10- and 4-minutes intra-service time) and determined 90461 requires more physician work, time and intensity, thus should be valued higher.

The RUC also compared 90461 to the second top key reference service 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20, 4 minutes intra-service time and 7 minutes total time) and determined 90461 requires slightly less physician work and time to perform.

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 of intra-service time and 6 minutes total time) and 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.19, 5 minutes of intra-service time and 6 minutes of total time), which require similar physician work and time. The RUC concluded that CPT code 90461 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.18 for CPT code 90461.**

90471 ***Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)***
The RUC reviewed the survey results from 100 physicians and nurse practitioners and determined that the current work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service time. The RUC discussed that the survey respondents indicated the median time had decreased. However, after further inspection of the survey results, the specialty societies indicated that the survey median time was skewed by those who completed the survey because it was not representative of those who typically perform this service. Of the 100 survey responses, 83 were from pediatrics and only 17 were from other primary care organizations. The pediatricians are atypical users of the adult codes and do not spend the same amount of time counseling since they would report 90460 and 90461 in those instances. The 17 responses from other primary care organizations support the current time of 7 minutes, thus the RUC agreed there is no evidence to change the physician time. The specialty societies indicated that

counseling is typical and provided in over 50% of the adult immunization administration codes 90471 and 90472; however, it is not required.

Survey Data Breakdown

CPT	Specialty	Responses	Response %	Median Time	2019 Medicare Claims Performance
90471	Pediatrics (AAP)	83	83%	3 min	0.5%
	Internal Med (ACP)	6	6%	5 min	26%
	Nurse Practitioners (ANA)	6	6%	9 min	17%
	Ob/Gyn (ACOG)	5	5%	9 min	0.3%
	Family Medicine (AAFP)	0			35%
	Total	100			

The RUC determined that the surveyed was flawed because the respondents who are not the predominant performers of this service skewed the results and further, there is no evidence that the current physician work or time has changed. The RUC concurred that the current work RVU of 0.17 and 7 minutes of intra-service time appropriately account for the work and time required to perform CPT code 90471. This valuation maintains the relativity and rank order with the pediatric immunization administration code, with 90471 being appropriately lower, as there is slightly less education and discussion about vaccination hesitancy that is required for CPT code 90460. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

For additional support, the RUC referenced CPT codes 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17, 3 minutes intra-service time and 7 minutes total time), 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. Usually, the presenting problem(s) are minimal.* (work RVU = 0.18, 5 minutes intra-service and 7 minutes total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time), all which require similar physician work and total time. The RUC concluded that the current value and time of CPT code 90471 should be maintained. **The RUC recommends a work RVU of 0.17 for CPT code 90471.**

90472 ***Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)***

The RUC discussed CPT code 90472 and came to the same determination, as for 90471, that the survey was flawed because the respondents who are not the predominant performers of this service skewed the results. Of the 97 survey responses, 81 were from pediatrics and only 16 were from other primary care organizations. The pediatricians are atypical users of the adult codes and do not spend the same amount of time counseling since they would report 90460 and 90461 in those instances. The 16 responses from other primary care organizations support the current time of 7 minutes, thus the RUC agreed there is no evidence to change the physician time. The specialty societies indicated that counseling is typical and provided in over 50% of the adult immunization administration codes 90471 and 90472; however, it is not required.

Survey Data Breakdown

CPT	Specialty	Responses	Response %	Median Time	2019 Medicare Claims Performance
90472	Pediatrics (AAP)	81	84%	3 min	0.4%
	Internal Med (ACP)	6	6%	5 min	32%
	Nurse Practitioners (ANA)	5	5%	5 min	12%
	Ob/Gyn (ACOG)	5	5%	8 min	0.4%
	Family Medicine (AAFP)	0			42%
	Total	97			

The RUC determined that there is no evidence that the current physician work or time has changed. The RUC concurred that the current work RVU of 0.15 appropriately accounts for the work required to perform this add-on service. The RUC recommends 7 minutes of intra-service time. This valuation maintains the relativity with the pediatric immunization administration code, with 90472 being appropriately lower as there is slightly less education and discussion about vaccination hesitancy that is required for CPT code 90461. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

For additional support, the RUC referenced 78730 *Urinary bladder residual study (List separately in addition to code for primary procedure)* (work RVU = 0.15 and 5 minutes of intra-service and total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time). The RUC concluded that the current value and time of CPT code 90472 should be maintained. **The RUC recommends a work RVU of 0.15 for CPT code 90472.**

90473 ***Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)***
The RUC determined that the survey was flawed because the respondents who are not the predominant performers of this service skewed the results and there is no evidence that the physician work and time has changed for this service.

The RUC agreed with the specialty societies that the work required for the intranasal/oral immunization administration is the same as the intramuscular immunization administration services. The RUC determined that the current work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service time. This valuation maintains the relativity and rank order with the pediatric immunization administration code, with 90473 being appropriately lower, as there is slightly less education and discussion about vaccination hesitancy as is required for CPT code 90460. The RUC noted that the immunization administration services are typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time recommended is not duplicative from what is included in the E/M visit.

For additional support, the RUC referenced CPT codes 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17, 3 minutes intra-service time and 7 minutes total time), 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. Usually, the presenting problem(s) are minimal.* (work RVU = 0.18, 5 minutes intra-service and 7 minutes total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6

minutes total time), all which require similar physician work and time. The RUC concluded that the current value and time of CPT code 90473 should be maintained. **The RUC recommends a work RVU of 0.17 for CPT code 90473.**

90474 ***Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)***
The RUC determined that the survey was flawed because the respondents who are not the predominant performers of this service skewed the results and there is no evidence that the physician work and time has changed for this service.

The RUC agreed with the specialty societies that the work required for the intranasal/oral immunization administration services are the same as the intramuscular immunization administration services. The RUC determined that the current work RVU of 0.15 appropriately accounts for the work required to perform this add-on service. The RUC recommends 7 minutes of intra-service time. This valuation maintains the relativity with the pediatric immunization administration code, with 90474 being appropriately lower as there is slightly less education and discussion about vaccination hesitancy as is required for CPT code 90461.

For additional support, the RUC referenced 78730 *Urinary bladder residual study (List separately in addition to code for primary procedure)* (work RVU = 0.15 and 5 minutes of intra-service/total time) and MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16, 4 minutes of intra-service time and 6 minutes total time). The RUC concluded that the current value and time of CPT code 90474 should be maintained. **The RUC recommends a work RVU of 0.15 for CPT code 90474.**

G0008 ***Administration of influenza virus vaccine***
G0009 ***Administration of pneumococcal vaccine***
G0010 ***Administration of hepatitis b vaccine***
HCPCS codes G0008, G0009 and G0010 for the administration of the vaccines are not paid on the Medicare Physician Fee Schedule. The Medicare Claims Processing Manual instructs that beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (recommended work RVU = 0.17 and 7 minutes intra-service time). The specialty societies indicated, and the RUC recommends maintaining that link. **The RUC recommends 7 minutes intra-service time and a work RVU of 0.17 for codes G0008, G0009 and G0010.**

Practice Expense
The Practice Expense (PE) Subcommittee discussed and accepted compelling evidence based on flawed methodology due to CMS hard coding as well as change in technique, as detailed in the PE summary of recommendation (SOR). Based on acceptance of compelling evidence, the PE Subcommittee reviewed the direct practice expenses for these services. It was clarified that 3 minutes of CA011 *Provide education/obtain consent* is typical for all these immunization administration services. The specialty societies explained, and the PE Subcommittee agreed, that a vaccination information statement (VIS) is required by Federal law to be presented and reviewed with patients for every vaccine administered. Even if it is a yearly vaccination, individuals must be presented and informed of both the benefits and risks of the vaccine. The PE Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Dark Adaption Eye Exam (Tab 20)
Presenters: Charles Fitzpatrick, OD (AOA), David Glasser, MD (AAO), Ankoor Shah, MD (AAO) and John Thompson, MD (ASRS)

In July 2020, the Relativity Assessment Workgroup identified one CPT code 92284 *Dark adaptation examination with interpretation and report* with 2019e Medicare utilization over 30,000. The Workgroup requested that the specialty societies submit an action plan addressing CPT code 92284 for January 2021. In January 2021, the RUC agreed with the specialty society that this service be surveyed for the April 2021 RUC meeting. The RUC noted that the family of services should be identified on the level of interest (LOI). The specialty societies indicated that there are no additional codes in this family. CPT 92284 is in a section of CPT labeled "Other Specialized Services" which contains several unrelated services performed using different techniques with different and unrelated physician work.

92284 ***Dark adaptation examination with interpretation and report***
The RUC reviewed the survey results from 45 ophthalmologists, retina specialists and optometrists for CPT code 92284 and determined that a direct work RVU crosswalk to CPT code 76514 *Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)* (work RVU = 0.14, 5 minutes of total time) appropriately accounts for the work required to perform this service. The RUC recommends 1 minute of pre-service time, 3 minutes of intra-service time, 1 minute of immediate post-service time, totaling 5 minutes for CPT code 92284. The specialty societies agreed that the recommended physician work and total time is more representative of the physician or other qualified healthcare professional (QHP) work associated with this procedure than the survey 25th percentile work RVU value of 0.45. The specialty society also noted that the recommended reduction in total time (from the current 36 minutes of total time) is due in part to the fact that CPT code 92284 is typically performed on the same date of an office or eye visit service.

The RUC discussed that CPT code 92284 is a diagnostic service but noted the manufacturer of the device used to perform this service markets the new model of this device to be used for both screening and diagnosis. The specialty societies confirmed that the work associated with CPT code 92284 is diagnostic in nature and that CPT code 92284 was not intended to be utilized for screening services. The specialty societies explained that intra-service work associated with CPT code 92284 involves physician or QHP interpretation and analysis of a machine generated data display to make a differential diagnosis. **The RUC recommends that CPT code 92284 be referred to CPT to editorially revise and include the word "diagnostic' in the code descriptor**.

The RUC compared CPT code 92284 to MPC code 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 6 minutes of total time) and discussed the similarity in the type of work with respect to interpretation and reporting while also noting the more complex nature of ECG interpretation which justifies a slightly higher work RVU value and 1 minute of additional total time. The RUC noted that both services would appropriately have an identical work per unit time of 0.028. The RUC also compared CPT code 92284 to CPT code 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17, 6 minutes of total time). **The RUC recommends a work RVU of 0.14 for CPT code 92284.**

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

New Technology
This service will be placed on the New Technology list and be re-reviewed by the RUC to ensure correct valuation and utilization assumptions. The RUC will review the typical technology used to perform this service when it is next re-evaluated, acknowledging that the device included in proposed direct practice costs recently was very recently replaced with a newer technology.

Practice Expense
The Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification and noted that the recommended reduction in practice expense inputs represents a greater than 50 percent decrease in direct practice expense costs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

RUC Referral to CPT
The RUC recommends CPT code 92284 be referred to CPT to editorially revise and include the word "diagnostic' in the code descriptor. "Diagnostic dark adaptation examination with interpretation and report."

Anterior Segment Imaging (Tab 21)
Presenters: David Glasser, MD (AAO), Ankoor Shah, MD (AAO) and John Thompson, MD (ASRS)

In 2011, CPT code 92286 was originally identified via the *Harvard Valued – Medicare Utilization over 30,000* screen and code 92287 was added as part of the family for review. The American Academy of Ophthalmology (AAO) indicated that apart from utilizing an image, codes 92286 and 92287 have completely different clinical indications and conditions. CPT code 92286 is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow-up care of post corneal transplant patients. The specialty societies believed that coding education and publication of a CPT Assistant article may help clarify the difference between codes 92287 and 92235. The RUC recommended that the specialty society develop a CPT Assistant article to clarify the difference between CPT codes 92287 and 92235.

In October 2018, the Relativity Assessment Workgroup reviewed a list of RUC referrals for CPT Assistant articles from 2013-2016. The Workgroup requested action plans for January 2019. In January 2019, the RUC recommended to review this service in two years to determine if the article and CPT changes were effective. In December 2020, the specialty societies noted that the CPT Assistant article addressed concerns with the appropriate reporting of macular degeneration. Medicare claims data for 2018 indicated that there is no confusion between 92287, 92286 or 92132. The diagnoses associated with claims for CPT 92287 do not include the glaucoma, cornea, or lens diagnoses which would be associated with CPT 92286 or 92132. However, the specialty societies noted that this service is Harvard valued and would benefit to be surveyed to include a vignette, description of work, updated physician time and valuation. A Workgroup member also commented that 92287 is frequently reported with fluorescein angiography of retina (92235). The RUC recommended that CPT code 92287 be surveyed for the April 2021 RUC meeting. The specialty societies indicated that despite its appearance as a "child" code of 92286, these are two wholly unrelated services in terms of instrumentation, diagnoses, and physician work.

92287 ***Anterior segment imaging with interpretation and report; with fluorescein angiography***
The RUC reviewed the survey results from 30 ophthalmologists and retina specialists for CPT code 92287 and determined that a direct work RVU crosswalk to MPC code 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes of intra-service and 12 minutes total

time) appropriately accounts for the work required to perform this service. The RUC recommends 1 minute of pre-service time, 10 minutes of intra-service time, and 1 minute of immediate post-service time. The RUC noted that 92287 is performed with an office or eye visit 95 percent of the time. The RUC ensured that its work and time recommendations represent work that is distinct and separate from the same-day office or eye visit services.

The RUC noted that both CPT code 92287 and CPT code 92250 are performed on both eyes and that the 1 minute of pre-service time is associated with entry of patient data into the electronic health record. The RUC also noted that the recommendation to decrease the valuation of 92287 reflects the marginal decrease in time.

The RUC compared CPT code 92287 to CPT code 92201 *Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral* (work RVU = 0.40, 10 minutes of intra-service and 12 minutes of total time) determined that both services require nearly identical physician work, time and intensity, which supports the RUC recommended work RVU valuation of 92287. The RUC also compared CPT code 92287 to MPC code 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU = 0.40, 8 minutes of intra-service and 11 minutes of total time). The RUC concluded that CPT code 92287 should be valued based on a direct work RVU crosswalk to MPC code 92250. **The RUC recommends a work RVU of 0.40 for CPT code 92287**.

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

Practice Expense
The Practice Expense (PE) Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. The RUC discussed whether a butterfly needle (SC030) and Bandaid (SG021) are included in this procedure even though this is often performed with retinal fluorescein angiography. The specialty societies clarified that it is typical to remove the butterfly needle and bandage the arm after the initial push rather than attempting to reuse the needle. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

XII. RUC HCPAC Review Board (Tab 22)

Richard Rausch, DPT, MBA, Co-Chair, provided a summary of the March 16, 2021 HCPAC Review Board Report. He noted that the following CPT codes will be added to the HCPAC MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
92526	Treatment of swallowing dysfunction and/or oral function for feeding	1.34	XXX	02-2009	133,424
92610	Evaluation of oral and pharyngeal swallowing function	1.30	XXX	02-2009	22,897

The RUC filed the HCPAC Report.

XIII. Research Subcommittee (Tab 23)

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

- **Minutes, February 23rd RSC Specialty Requests Conference Call and Pre-Call/Post-Call Electronic Review**

The Research Subcommittee report from the February 23rd conference call included in Tab 23 of the April 2021 agenda materials was approved without modification.

- **Discussion - IWPUT Comparisons** *(new item)*

At the April 2019 RUC meeting, the RUC recommended for the full increase of work and physician time for office visits to be incorporated into the surgical global periods for each CPT code with bundled post-operative office visits. CMS decided to not accept this RUC recommendation, resulting in bundled post-operative office visits in the surgical global period having divergent lower values relative to separately-reported office visits. Due to CMS' decision, the RUC Database and the Intra-service Work Per Unit of Time (IWPUT) calculator spreadsheet continue to use the 2020 office visit work values as inputs to the IWPUT formula. At the January 2021 RUC meeting, a RUC member requested that the Research Subcommittee review the impact to IWPUT comparisons based on CMS' decision. The RUC agreed to refer this request to the Research Subcommittee to review the impact on IWPUT comparisons. To facilitate this discussion, AMA Staff had provided the Subcommittee with an analysis comparing the IWPUT for high volume 010-day and 090-day codes before and after adjusting the IWPUT formula inputs for the 2021 office visit increase.

Several Subcommittee members concurred that having some metric for analyzing physician work intensity between services is important. The IWPUT formula is intended to per minute work RVU only for intra-service portion of a service to impute the physician work intensity assigned to the value of a service. Some Subcommittee members suggested for the Subcommittee to come up with new metrics for physician work intensity to either supplement or replace the IWPUT metric. A Subcommittee member noted that the current IWPUT formula, which retains the 2020 office visit values, reflects CMS' decision to not accept the RUC recommendation to increase the value of bundled office visit services and that the formula still retains some utility.

The Subcommittee had agreed to continue this discussion at its next meeting coinciding with the October 2021 RUC meeting. The Subcommittee also noted its concern that the IWPUT formula has lost some validity and utility.

- **Review of Specialty Request Process** *(new item)*

Periodically, the Research Subcommittee discusses and refines its requirements and other guidance for specialty societies that are seeking Research Subcommittee review for requests pertaining to the RUC survey process for individual codes. The Subcommittee discussed the following refinements:

  - **Targeted Sample Requests**

If a society requests approval to use a vendor list but also notes that they plan to separately include a random sample of their membership, the request is consistently approved without modification. AMA staff suggested an alternative where societies could use targeted survey sample methodology provided they comply with a list of specific requirements. This would be

similar to the current process for when a society wishes to use a random survey sample from one or more of their member sections/categories. Whenever a vendor lists is use, societies are required to have the vendors sign a Vendor Attestation Statement.

A Research Subcommittee member noted that targeted sample requests that involve a vendor lists are only done currently for services that involve new technology or very low volume. Several Subcommittee members spoke in general support of the idea. The Vice Chair noted that the rules should require that the vendor provide their complete list of all US physicians trained in performing the service.

The Research Subcommittee approved that certain targeted survey sample requests would no longer need to be reviewed and approved by the Subcommittee provided. AMA staff, the Chair and Vice Chair will draft the specific rules and provide them for the Subcommittee's consideration at the October 2021 Subcommittee meeting.

- **Reference Service List Review**

Research Subcommittee review of Reference Service Lists (RSLs) is never a requirement and when the Subcommittee does review RSLs, it provides general non-binding guidance to societies. Even though RSL review is not required, the Subcommittee spends a lot of time reviewing and discussing these requests on each specialty request review call.

Subcommittee members noted that it is not uncommon for draft RSLs to not align with the RSL guidelines provided to societies. The Chair inquired whether it would be possible for AMA RUC staff to pre-review RSLs submitted by societies to see if it followed the general RSL guidelines provided to societies. AMA staff noted that they had previously discussed this idea and that by making the submission deadline 1-2 days earlier, it would be possible. **The Research Subcommittee requests for the AMA RUC staff to create a process for the pre-review of RSL requests.**

Separately, the Chair noted that it could be beneficial to have some additional indicator whether the societies requested RSL review and whether the guidance that was provided was followed (ie additional fields on the summary of recommendation form (SOR). AMA RUC staff noted that, starting with the April meeting, relevant excerpts from the Research Subcommittee report with be included in each RUC meeting tab.

The RUC approved the Research Subcommittee Report

XIV. Relativity Assessment Workgroup (Tab 24)

Doctor Proctor provided the Relativity Assessment Workgroup report to the RUC. He indicated the Workgroup reviewed two action plans.

The first action plan reviewed was for codes G0407 & G0408 that were identified via the CMS/Other Source with Medicare Utilization over 20,000. The Workgroup noted that there likely will be numerous changes in telemedicine utilization due to the pandemic. **Therefore, the RAW recommends these services be reviewed in 2 years (April 2023) after additional data are available. Second, there should be a CPT Assistant article, if appropriate or other CMS education regarding who should be reporting these services. The RAW also would like to inform CMS of possible misreporting of these services. Based on the *Medicare Provider Utilization and Payment Data Physician and Other Supplier PUF CY 2018* data, seven to eight**

individual Nurse Practitioners account for approximately 50% of G0407 and G0408 services provided.

CPT code 73580 was identified via the high volume growth screen in 2008 and the Relativity Assessment Workgroup has reviewed multiple times. In 2008, the specialty commented the increase in utilization was due to a non-coverage decision for arthroscopic lavage. Physicians were using codes 73580 and 27370 to report different procedures. In February 2009, these procedures were referred to CPT for possible deletion of 73580 and 27370 and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes. In October 2009, the RUC recommended that the specialty society develop a CPT Assistant article to address misreporting of arthrography codes--the article was published in June 2012. In April 2015, the Workgroup reviewed services for which the RUC recommended that a CPT Assistant article be developed. The Workgroup requested that the specialty societies develop an action plan to address the increase in utilization and effectiveness of the CPT Assistant article. In October 2015, the Workgroup recommended to review in 2017 to determine if 2015 CPT changes were effective. In October 2017, the RUC recommended that the RAW review this service in another three years in October 2020, via action plan and show data for the total joint replacement codes in correlation with this service.

In October 2020, the Workgroup discussed the long history of the identification of code 73580 and noted that this service has never been surveyed and remains CMS/Other sourced. The specialty societies noted that the increased utilization was due to miscoding of the related CPT code 27370 *Injection of contrast for knee arthrography*. To address this miscoding, CPT code 27370 was deleted and replaced with a new CPT code 27369, *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography*. The new CPT code was valued by the RUC in October 2017. CPT code 27370 was deleted in 2019 and a CPT Assistant article was published in August 2019. CPT code 73580 utilization has decreased in 2019 concurrent with the deletion of 27370 and clarification of the appropriate use of these codes. The specialty societies noted that the RUC rationale for CPT code 27369 provides additional information, including why these services were not previously bundled. However, the Workgroup noted that codes 73580 and 27369 will always be reported in conjunction with one another. The Workgroup also noted that that Rheumatology and Family Medicine are the primary providers of code 73580 and should be involved with the review of this service. The Workgroup recommended that CPT code 73580 be referred to CPT to be bundled with CPT code 27369 *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography.*

In February 2021, the specialty society notified AMA staff that they will not be taking these services to CPT to bundle at this time. Since these services were not addressed based on the last RUC recommendation, they are referred to the RAW to review an action plan at the March 2021 meeting.

The specialty societies indicated that the utilization has decreased for 2019 after the coding changes and CPT Assistant article were published, but they would like to see how this will further drop after additional data are available. The Workgroup noted that code 73580 was never surveyed and although it describes *Radiologic examination, knee, arthrography, radiological supervision and interpretation*, based on Medicare data, Diagnostic Radiology performs this service only 2.3% of the time. **The primary providers are Rheumatology, Family Medicine, Orthopedic Surgery and Physical Medicine and Rehabilitation. The Workgroup recommends that that CPT code 73580 be surveyed for the October 2021 RUC meeting. The Workgroup also notes that the effectiveness of the CPT Assistant article for CPT code 27369 should be reexamined in two years (October 2023).**

The RUC approved the Relativity Assessment Workgroup report.

XV. Multi-Specialty Points of Comparison Workgroup (Tab 25)

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

The Workgroup reviewed proposals from several specialty societies and representatives from these specialty societies attended the meeting on March 24, 2021 to speak to their proposals; specialty societies were encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list.

The Workgroup was reminded that codes on the MPC should ideally include: codes that have gone through the RUC survey process; codes that have RUC reviewed time; codes with utilization greater than 1,000; and codes performed by multiple specialties.

The Workgroup agreed to add 13 specialty-recommended codes to the MPC list; delete 39 codes the specialties recommended for deletion and agreed to maintain 19 codes that have not been reviewed by the RUC in over 15 years. The Workgroup also accepted the withdrawal of 4 codes that specialty societies had recommended for addition and recommended that 12 codes that specialty societies had submitted for deletion be maintained on the MPC list.

The Workgroup recommended that the following CPT codes be added to the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	13.50	090	2017-01	1,767
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	9.04	010	2013-04	1,366
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.80	000	2015-10	699,990
70490	Computed tomography, soft tissue neck; without contrast material	1.28	XXX	2017-01	68,230
70491	Computed tomography, soft tissue neck; with contrast material(s)	1.38	XXX	2017-01	279,888
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	1.62	XXX	2017-01	25,867
74220	Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	0.60	XXX	2019-01	196,573

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
74246	Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered	0.90	XXX	2019-01	34,438
85060	Blood smear, peripheral, interpretation by physician with written report	0.45	XXX	2017-04	185,409
85097	Bone marrow, smear interpretation	0.94	XXX	2017-04	140,727
88323	Consultation and report on referred material requiring preparation of slides	1.83	XXX	2016-01	35,000
92273	Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)	0.69	XXX	2018-01	68,699
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	0.35	ZZZ	2012-04	141,249

The Workgroup recommended that the following CPT codes be withdrawn as recommended by the specialty and not be added to the MPC List:

The American Society of Plastic Surgeons (ASPS) withdrew its requests to add CPT codes 19316 and 19318 following Workgroup discussion that code 19316 is performed 81.6% of the time by Plastic and Reconstructive Surgery and that code 19318 is performed 95.4% of the time by Plastic and Reconstructive Surgery. Workgroup members noted that 19316 does not fill a significant work RVU gap on the MPC list. The American Academy of Ophthalmology (AAO) withdrew its request to add CPT code 65210 to the MPC list following Workgroup members discussion that CMS did not accept the RUC recommended work RVU for the code. The Society of Interventional Radiology (SIR) withdrew its request to add CPT code 47383 to the MPC list following Workgroup member discussion about the low volume of utilization of this code (performed 245 times in 2019) and that the code does not fill a work RVU gap in the MPC list.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
19316	Mastopexy	11.09	090	2020-01	3,196
19318	Breast reduction	16.03	090	2020-01	7,501
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	8.88	010	2014-04	245
65210	Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	0.61	000	2017-04	25,202

The Workgroup recommended that the following CPT codes be deleted from the MPC list:

The Workgroup recommended 39 codes be removed from the MPC list. These recommended deletions include Evaluation and Management (E/M) codes that were recently revised by the CPT Editorial Panel and are under RUC review for the CPT 2023 cycle and CPT codes for which CMS has not yet determined a valuation (i.e., CPT codes that were reviewed during the October 2020 and January 2021 RUC meetings). The recommended deletions also include several codes that AMA staff screened as having not been RUC reviewed in the past 15 years and that specialty societies recommended to be sunset from the current MPC list.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	1.05	010	2005-08	27,729
11604	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm	3.17	010	2005-08	38,989
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	9.06	090	2010-10	5,470
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	43.98	090	2005-08	871
49505	Repair initial inguinal hernia, age 5 years or older; reducible	7.96	090	2005-08	50,710
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	22.22	090	2005-04	23
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	6.55	010	2005-04	1,589
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	17.31	090	2005-09	5,391
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	12.16	090	2005-09	1,781
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	3.78	010	2011-04	358,450
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	7.97	090	2005-08	54,853
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report	0.35	XXX	2006-02	249,200
94004	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day	1.00	XXX	2006-04	30,542

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
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	0.17	XXX	2009-10	301
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	0.37	ZZZ	2005-04	85,904
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	1.92	XXX	2006-02	1,759,562
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	2.61	XXX	2006-02	6,459,408
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of	3.86	XXX	2006-02	10,626,847

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.				
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	0.76	XXX	2006-02	6,736,945
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	1.39	XXX	2006-02	44,656,174
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	2.00	XXX	2006-02	24,607,697

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
99238	Hospital discharge day management; 30 minutes or less	1.28	XXX	2006-02	2,550,501
99239	Hospital discharge day management; more than 30 minutes	1.90	XXX	2006-02	5,189,830
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	0.48	XXX	2018-04	67,730
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	0.93	XXX	2018-04	352,496
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	1.60	XXX	2018-04	2,744,710
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are	2.74	XXX	2018-04	5,415,650

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.				
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	4.00	XXX	2018-04	11,514,274
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	1.64	XXX	2007-02	336,776
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically,	3.06	XXX	2007-02	1,389,990

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	45 minutes are spent at the bedside and on the patient's facility floor or unit.				
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	1.16	XXX	2007-02	11,302,104
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	1.55	XXX	2007-02	10,009,767
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	2.35	XXX	2007-02	1,671,664

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.	1.71	XXX	2007-02	100,126
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	2.63	XXX	2007-02	57,317
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	3.46	XXX	2007-02	67,147
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians,	1.72	XXX	2007-02	1,241,609

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.				
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.	2.46	XXX	2007-02	1,676,057
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.	3.58	XXX	2007-02	547,337

The Workgroup recommended that the following CPT codes (that were recommended by the specialty to delete) be maintained on the MPC List:

The Workgroup recommended that 12 CPT codes not be deleted, contrary to the recommendation from the American Academy of Orthopaedic Surgeons (AAOS). Workgroup members cited numerous reasons that these codes should remain on the MPC list: they represent a wide range of work RVUs; they represent a wide range of global periods; three of the codes have 2019 utilization greater than 100,000; the removal of these codes would create work RVU gaps in the MPC list; and their removal would leave only one code on the MPC list for which Orthopaedic Surgery is the

dominant specialty. The Workgroup recommended that AAOS may consider the deletion of these codes at a future MPC Workgroup meeting with a strong rationale for their removal, as well as a list of codes to replace the deletions.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	000	2014-01	1,069,935
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	7.41	090	2009-02	940
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	5.91	090	2009-02	1,689
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	6.74	090	2009-02	948
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	7.56	090	2008-04	1,034
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	7.13	090	2009-02	1,832
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	6.74	090	2009-02	4,056
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	7.07	090	2007-02	2,079
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	7.42	090	2007-02	1,657
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	5.86	090	2007-02	1,365
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	15.37	090	2013-01	101,838

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	3.47	ZZZ	2013-01	128,927

The Workgroup recommended that the following CPT codes (not RUC reviewed for over 15 years) be maintained on the MPC list:

AMA staff compiled a list of codes on the MPC list that have not been RUC reviewed in the past 15 years; there are 38 such codes on the MPC list. AMA staff worked with specialty societies to identify codes from this review that they would recommend retaining on the MPC list; specialty societies recommended retaining 21 of these codes. Workgroup members discussed these codes and recommended that 19 of these codes should remain on the MPC list; the Workgroup recommended the deletion of the remaining 19 codes that have not been RUC reviewed in the past 15 years. The Workgroup also recommended that the Society of Thoracic Surgeons (STS) identify replacement CPT codes in the work RVU range of CPT codes 33426, 33534, and 33641 that have been more recently reviewed through the RUC process the next time there is a solicitation for MPC changes in 2022.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	0.90	010	2005-08	24,133
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	1.45	010	2005-08	115,439
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	1.84	010	2005-08	48,049
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	1.53	010	2005-08	30,002
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	1.77	010	2005-08	30,312

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	2.34	010	2005-08	8,316
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	2.07	010	2005-08	23,703
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	3.11	010	2005-08	25,312
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	2.17	010	2005-08	29,582
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1-2 cm	2.62	010	2005-08	89,442
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	3.42	010	2005-08	32,484
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	9.23	090	2005-08	90,113
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	43.28	090	2005-08	3,163
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	39.88	090	2005-08	5,001
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	090	2005-08	1,849
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	1.73	000	2006-02	20,612
70355	Orthopantogram (eg, panoramic x-ray)	0.20	XXX	2005-08	34,300
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	XXX	2005-08	5,905,780
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	2.25	ZZZ	2005-08	560,661

Workgroup members discussed the MPC Workgroup policy precedent established at the January 2019 and April 2019 MPC Workgroup meetings whereby AMA staff would identify CPT codes on the MPC list that have not been RUC reviewed in the past 15 years. Workgroup members noted that any codes that have not been reviewed since 2007 would not include standardized pre-service time packages and therefore should be identified for potential replacement on the MPC list. **The Workgroup agreed that AMA staff will develop policy and process recommendations for this**

review – with specialty society input – to be presented to the MPC Workgroup at the October 2021 RUC meeting.

The Workgroup also discussed the proposal by the American College of Surgeons (ACS) for the Workgroup to temporarily remove any CPT codes that are under current RUC review or do not have a work RVU determined by CMS. **AMA staff will develop policy and process recommendations for these criteria – with specialty society input – to be presented to the MPC Workgroup at the October 2021 RUC meeting to continue this review moving forward.**

The Workgroup also discussed the necessity that CPT codes included on the MPC list have work values supported by robust RUC surveys and will discuss how to handle any codes that were valued using a direct work RVU crosswalk through the RUC process at the Workgroup's next meeting.

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

XVI. Practice Expense Subcommittee (Tab 26)

Doctor Scott Manaker, Chair, provided a summary of the Practice Expense (PE) Subcommittee report including two workgroup meetings that occurred in March 2021.

The Pre-Service Time Global Conversion Workgroup considered how to handle changes in global periods from 090-day to 000- or 010-day. After thorough discussion and review of the history of the pre-service time packages, the Workgroup concluded that there should be no change in how codes with conversions in global periods from 090-day to 000- or 010-day are handled regarding pre-service clinical staff time. It was re-emphasized that information about the amount of pre-service clinical staff time and a change from a 090-day global to a 000- or 010-day global should be fully described and justified in the PE SOR. **The Workgroup determined that the current process of handling the conversion codes on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for these procedures and therefore recommends no change. The PE Subcommittee approved the report of the Pre-Service Time Global Conversion Workgroup.**

The Injection Packs Workgroup considered whether povidone solution (Betadine) continues to be typical or whether it should be replaced by chlorhexidine. While the Workgroup agreed that most of the codes would likely use Chloraprep, it was determined that the best approach would be to create an alternative pack so that specialties can select the pack with the most appropriate antiseptic. Specialty societies should consider the option of Betadine versus Chloraprep for individual codes when they provide practice expense proposals. **The PE Subcommittee reviewed the recommendations of the Injection Packs Workgroup and recommended that:**

1. **The RUC request that the Centers for Medicare and Medicaid Services (CMS) create an alternate basic injection pack to appropriately account for the typical antiseptic moving forward. The new pack should duplicate SA041 *pack, basic injection* with the addition of SJ081 *swab, patient prep, 1.5 ml (chloraprep)* and removal of supply items SJ041 *povidone soln (Betadine)* and SG009 *applicator, sponge tipped.***

2. **The RUC advise the specialty societies to consider the Betadine versus Chloraprep alternative basic injection packs and justify the appropriate antiseptic at the time of code review.**

The RUC approved the Practice Expense Subcommittee Report.

XVII. Novavax SARS-CoV-2 Immunization Administration (Tab 27)

Presenters: Megan Adamson, MD (AAFP), Suzanne Berman, MD (AAP), Jon Hathaway, MD (ACOG) and Steven Krug, MD (AAP)

On November 5, 2020, the CPT Editorial Panel created four codes to describe immunization administration (IA) by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. CPT codes 0001A and 0002A are used to report the first and second dose administration of the Pfizer-BioNTech COVID-19 vaccine (ie 30 mcg/0.3mL dosage, diluent reconstituted). CPT codes 0011A and 0012A are used to report the first and second dose administration of the Moderna COVID-19 vaccine (ie 100 mcg/0.5mL dosage.

On December 14, 2020, the CPT Editorial Panel created two codes to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. Codes 0021A and 0022A are used to report the first and second dose administration of the AstraZeneca vaccine. Subsequently on January 14, 2021, the CPT Editorial Panel created one new code to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine. Code 0031A is used to report the administration of the Janssen vaccine, which only requires a single dose.

Most recently, on April 5, 2021, the CPT Editorial Panel created two codes to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. Codes 0041A and 0042A are used to report the administration of the first and second dose of the Novavax vaccine.

These CPT codes, developed based on extensive collaboration with CMS and the Centers for Disease Control and Prevention (CDC), are unique for each of the five coronavirus vaccines as well as administration codes unique to each corresponding vaccine and dose. The new CPT codes clinically distinguish each COVID-19 vaccine for better tracking, reporting and analysis that supports data-driven planning and allocation. In addition, CPT Appendix Q was created to facilitate an easy guide for proper reporting of all SARS-CoV-2 vaccine CPT codes.

In April 2021, the RUC reviewed the two Novavax SARS-CoV-2 immunization administration codes. The specialty societies provided background on the previous valuation of CPT code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed.*

Background on Immunization Administration Valuation

During the October 2009 meeting, the RUC provided recommendations for CPT code 90640 *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 = 0.20 and 7 minutes intra-service time) and direct practice expense (PE) inputs. During the same meeting, the RUC reviewed recommendations for CPT code 90470 which was fast-tracked to address the immediate need to vaccinate against the 2009 H1N1 pandemic.

In 2009, at the request of the Department of Health and Human Services, the CPT Editorial Panel created new CPT code 90470 to assist the public health effort to immediately vaccinate for H1N1. CMS requested that the RUC immediately review the new service and provide recommendations on the estimated physician work and direct practice expense inputs necessary to provide the immunization. The RUC recommended the same work RVU of 0.20 and 7 minutes of intra-service time for H1N1 code 90470 as it did for CPT code 90460. Additionally, the RUC recommended the direct PE

inputs for CPT code 90470 be equivalent to CPT code 90460 with two primary exceptions. First, an additional two minutes of staff time were added to capture the additional work of identifying and contacting patients as the vaccine is provided by the state. In addition, the standard greet patient time of 3 minutes was added since an evaluation and management code is not additionally reported as part of the typical patient encounter for vaccinating during a pandemic.

CMS accepted the RUC recommendations for CPT code 90470, publishing a work RVU 0.20 and PE RVU of 0.42 on the 2010 Medicare Physician Payment Schedule (MFS), representing the resources utilized in vaccinating the public during a pandemic. CPT code 90470 was sunset at the end of the H1N1 pandemic.

CMS crosswalked CPT code 90460 to CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid*) (work RVU = 0.17) which, in turn, was hard coded to CPT code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17).

In the Proposed Rule for 2021, CMS noted that the IA payment rates resulting from the CPT code 96372 hard coding were substantially lower than the CDC regional maximum charges. CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services, as it is critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. The RUC reviewed all non-COVID related immunization codes at this April 2021 RUC meeting and submitted recommendations for these services.

Novavax SARS-CoV-2 (COVID-19) Immunization Administration

The RUC reviewed the specialty society recommendations and agreed that 0041A and 0042A should be crosswalked to the 2009 RUC recommendation for 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* (2009 recommended work RVU = 0.20 and 7 minutes of intra-service time). This is also the same work RVU established for 90470 during the H1N1 pandemic.

For additional support, the RUC referenced codes 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20 and 7 minutes total time), 99188 *Application of topical fluoride varnish by a physician or other qualified health care professional* (work RVU = 0.20 and 9 minutes total time) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 9 minutes total time).

In the case of some COVID-19 vaccine requiring two doses, the total physician work resources required for the first dose should be equivalent to those required for the second dose to account for the possibility that a patient may not return to the same physician or even the same physician group for the second dose administration. Valuation must account for any necessary physician work to confirm the details of a patient's first dose. The specialty societies indicated, and the RUC agreed, that the first and second dose both require 7 minutes of physician time. Data from the Phase III clinical trials indicated that patients receiving the second dose are more likely to experience adverse effects but the physician involvement addressing such questions are the same for both doses. The RUC agreed that there is no difference in physician work between the administration of the first and second dose, nor is there any difference in physician work or time to administer the Pfizer-BioNTech, Moderna, AstraZeneca, Janssen or Novavax immunizations. The RUC recommends the Novavax IA

codes be crosswalked to the 2009 RUC recommendations for CPT code 90460 with respect to work and intra-service time. **The RUC recommends a work RVU of 0.20 and intra-service time of 7 minutes for CPT codes 0041A and 0042A.**

Practice Expense
The Practice Expense (PE) Subcommittee thoroughly and extensively discussed the practice expense inputs involved with the SARS-CoV-2 immunization administration codes in the physician office setting in its December 2020 review of the Pfizer and Moderna IA codes and determined the same direct inputs apply to the AstraZeneca, Janssen and Novavax IA codes. The Subcommittee compared the direct PE inputs for the new IA codes with reference code 90460 and former CPT code 90470 and determined that the clinical staff times approved for code 90470 during the 2009 pandemic were appropriate. The inputs mirror the clinical staff times that had been in place for CPT code 90470. The Subcommittee also determined that new CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* would be utilized with these codes and confirmed that there is no overlap in clinical staff times, with what is already included in CPT code 99072. **The RUC strongly recommends that CMS approve payment for CPT code 99072 during the PHE.**

The specialty societies emphasized that though the clinical staff activities may be like other vaccination codes, the typical amount of clinical staff time for COVID-19 immunization administration is higher due for the to the requirements inherent in a public health emergency and due to these services not being typically reported with an evaluation and management service during a PHE. There was significant discussion regarding the considerable documentation requirements that accompany these COVID-19 immunization administration codes. There was agreement that 2 minutes was appropriate for the first dose of both vaccines to identify and contact appropriate patients and schedule immunization. The recommendation for CA033 *Perform regulatory mandated quality assurance activity (service period)* was maintained the same as was recommended for the Pfizer and Moderna IA codes, as L026A *Medical/Technical Assistant* is appropriate for this type of registry. A lesser amount of clinical staff time was allotted for CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)* with L037D *RN/LPN/MTA*, recognizing that more than baseline medical knowledge is required for this activity. There was also recognition that the initial data entry would require more time and the minutes for CA033 and CA034 in the subsequent codes were reduced accordingly. The CDC recommends 15 minutes of monitoring the patient following the administration of each dose for both vaccines. The PE Subcommittee agreed that the standard of 1 minute of clinical staff time to every 4 minutes of patient monitoring is appropriate, leading to 4 minutes of clinical staff monitoring time. A follow-up phone call from the patient to the practice to discuss symptoms or address questions was accepted as typical.

The PE Subcommittee extensively discussed the supply and equipment inputs associated with the initial Pfizer, Moderna, AstraZeneca and Janssen immunization administration codes. The same supplies are recommended for the Novavax IA codes with the previous adjustment, which includes 3 sheets of *SK057 paper, laser printing (each sheet)*. The typical CDC Vaccine Information Statement (VIS) is two pages (i.e., one sheet of laser paper, printed double sided). However, the emergency use authorization (EUA) for the Pfizer COVID VIS is 6 pages, the Moderna COVID VIS is 5 pages and the Janssen COVID VIS is 6 pages. It is anticipated that the Novavax COVID VIS (and future COVID VIS) will follow suit. **Therefore, the Practice Subcommittee amends the recommendation for SK057 accordingly (i.e., 3 sheets of laser paper, printed double sided) for all COVID IA codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A, 0041A and 0042A).** The remaining supplies recommended are: SB022 *gloves, non-sterile* to reflect a full pair and exclude any COVID-19 cleaning supplies including additional quantities of hand sanitizer and disinfecting

wipes/sprays/cleansers as these are included in CPT code 99072. The PE Subcommittee excluded any supplies that are included in the ancillary supply kit supplied by the Federal Government at no cost to enrolled COVID-19 vaccine providers.

The PE Subcommittee recommended new equipment item *refrigerator, vaccine medical grade, w-data logger sngl glass door,* the same equipment included in the Moderna IA codes (0011A and 0012A). In 2019, there was significant discussion about the existing equipment ED043 *refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates* and whether it was a direct or indirect expense. ED043 is the monitoring system and was retained as a direct expense in accordance with the spreadsheet. The medication-grade refrigerator is used solely to store highly expensive and fragile biologics for use at the time they are needed. Although the medications are stored for longer than the length of the service, it would be extremely difficult to determine typical length of storage as this varies across local sites. The RUC and CMS have a precedent of including refrigerators in direct expense costs and using the total clinical staff time for the equipment minutes, as was done for vaccination codes, including codes 90471, 90472, 90473, and 90474, where the equipment time for the refrigerator is equal to the total clinical staff time. The RUC recommends that the same refrigerator and monitor would be typical medical equipment for the AstraZeneca, Moderna, Janssen and Novavax vaccines. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Services
The RUC recommends that all COVID Immunization Administration codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A 0041A and 0042A) be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Modifier -51 Exempt
The RUC acknowledges that vaccines and immunizations are inherently precluded from the modifier -51 application and note that the revisions to the CPT guidelines are already in place, which include COVID immunizations.

XVIII. Other Business (Tab 28)

A RUC member requested that prior to a vote on compelling evidence, the rationale for compelling evidence is clearly stated to ensure the appropriate compelling evidence is approved and recorded.

An individual informed the RUC that some large physician practices are not yet incorporating the office visit increases in their physician compensation programs. A RUC member encouraged continued education on the new Evaluation and Management guidelines.

A general discussion about codes for which CMS did not accept RUC recommendations or implemented changes without any RUC review occurred. The RUC referred this issue to the **Administrative Subcommittee** to review the RUC's rules regarding determining work neutrality, compelling evidence and which codes are considered RUC reviewed. AMA staff were asked to develop an environmental scan and provide historical information for the Administrative Subcommittee. A RUC member asked staff to also summarize all codes for which CMS increased non-RUC reviewed services for the 2021 Medicare FFS and determine if these codes should be flagged in the database.

A RUC member requested that AMA staff present the historical information on the 23-hour visit policy for discussion at a **Research Subcommittee** meeting.

The RUC continued to discuss its support for inclusion of the office visit increases in the surgical global period. It was clarified that the survey respondents select the office visits based on the current 2021 E/M guidelines and definitions. AMA staff indicated that with each RUC recommendation submission, CMS is provided with a spreadsheet that articulates what the modifications to direct practice expense, time and valuation would be, if CMS were to adopt the RUC recommendation to fully incorporate the office visit increases into the surgical global periods. In addition to the recommendations based on the current CMS policy, AMA staff provide a spreadsheet that articulates the practice expense, time and valuation if the recommendations were not adopted. An excel document of all 010 and 090 days codes with work RVU, physician time and direct practice expense needed modifications to fully implement the RUC recommendations will be made available to the RUC.

RUC members requested that staff perform an analysis for the **Research Subcommittee** to have a general discussion about WPUT. The analysis will aggregate WPUT by global periods, code ranges, etc.

A RUC member requested that the **Research Subcommittee** review pre-service time packages for pediatric services. AMA staff noted that the relevant specialty societies performing these services should share recommendations with the Research Subcommittee.

RUC members expressed their appreciation for live editing of the spreadsheets and other efficiencies and created in the virtual meeting and suggested that AMA staff explore these improvements for in person meetings.

The RUC discussed the pre-facilitation process and the desire to continue this process virtually in the week(s) prior to a RUC meeting. It was noted that improvements in the "handout" and revised document process are needed to ensure that the reviewers and other RUC members are not burdened with unnecessary re-review of content.

The RUC adjourned at 4:35 p.m. on Saturday, April 24, 2021.