**AMA/Specialty Society RVS Update Committee**
**January 13-16, 2021**

**Meeting Minutes**

## I. Welcome and Call to Order

The RUC met virtually in January 2021 due to the COVID-19 pandemic. Doctor Peter Smith called the virtual meeting to order on Thursday, January 14, 2021 at 8:30 a.m. CT. The following RUC Members were in attendance:

Peter K. Smith, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Robert Dale Blasier, MD
Kathleen K. Cain, MD
Jim Clark, MD
Scott Collins, MD
Gregory DeMeo, DO
Verdi J. DiSesa, MD
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
Gregory Harris, MD
David F. Hitzeman, DO
Omar S. Hussain, DO
Timothy Laing, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
Dee Adams Nikjeh, PhD, CCC-SLP
Jordan Pritzker, MD
John H. Proctor, MD, MBA
Marc Raphaelson, MD
Christopher Senkowski, MD
Ezequiel Silva III, MD
Norman Smith, MD
Stanley W. Stead, MD, MBA
G. Edward Vates, MD
James C. Waldorf, MD
Thomas J. Weida, MD

Amr Abouleish, MD, MBA*
Amy Aronsky, DO*
Jennifer Aloff, MD*
Gregory L. Barkley, MD*
Eileen Brewer, MD*
Joseph Cleveland, MD*
William D. Donovan, MD, MPH*
William F. Gee, MD*
David C. Han, MD*
John Heiner, MD*
Peter Hollmann, MD*
Gwenn V. Jackson, MD*
S. Kalyan Katakam, MD, MPH*
Mollie MacCormack, MD*
Lance Manning, MD*
John McAllister, MD*
Eileen Moynihan, MD*
M. Eugene Sherman, MD*
James L. Shoemaker, MD*
Clarice Sinn, DO*
Michael J. Sutherland, MD*
Donna Sweet, MD*
Timothy H. Tillo, DPM*
Mark T. Villa, MD*
David Wilkinson, MD, PhD*
David Yankura, MD*

*Alternate

## II. Chair's Report

Doctor Smith 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 Smith conveyed the following guidelines related to Confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement electronically prior to this meeting).
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
  - Recording devices are prohibited.
  - The full confidentiality agreement may be found on the RUC Collaboration site (Structure and Functions).

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

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

- Doctor Smith welcomed the following Contractor Medical Director:
  - Richard W. Whitten, MD, MBA

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

- Doctor Smith announced departing RUC Members:
  - Dee Adams Nikjeh, PhD, CCC-SLP
  - Verdi DiSesa, MD
  - Matthew Grierson, MD
  - Omar Hussain, MD

- Doctor Smith conveyed the Lobbying Policy:
  - "Lobbying" means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.

- Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
- Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
- Full lobbying policy found on Collaboration site (Structure and Functions).

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

- Doctor Smith conveyed the following procedural guidelines related to Voting:
  - Work RVU = 2/3 vote
  - Motions = Majority vote
  - RUC members will vote on 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 28 votes.

- Doctor Smith 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 Smith explained the following RUC established thresholds for the number of survey responses required:
  - Codes with $\geq$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.

## 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 thanked Doctors Peter Smith and Michael Bishop for their years of service to the RUC since this would be their final RUC meeting serving as chair and vice chair. A video tribute was shown to all RUC participants in attendance thanking Doctors Smith and Bishop for their hard work and mentorship

throughout the years. The RUC will celebrate Doctors Smith and Bishop's years of service when the public health emergency ends and it is safe to meet in-person.

- Peter K. Smith, MD (15 years)
  - RUC Member (2006-2015)
  - RUC Chair (2015-2021)

- Michael Bishop, MD (21 years)
  - RUC Member (2000-2015)
  - RUC Vice-Chair (2015-2021)

- Ms. Smith welcomed and introduced the new RUC leadership who will assume their new roles after the RUC recommendation submission to CMS (March 1, 2021). The AMA Board of Trustees has appointed:
  - RUC Chair – Ezequiel Silva III, MD
  - AMA Representative – Peter Hollmann, MD
  - Alternate AMA Representative – Robert Zwolak, MD

- Ms. Smith conveyed the following information regarding the new RUC Database application:
  - The new RUC Database is available at https://rucapp.ama-assn.org
  - Accessible both online and offline from any device, including smartphones and tablets
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - Major changes/ new features for the new RUC Database application include:
    - Access the Database both on the internet, as well as download the application to your web browser's cache to enable full offline functionality.
    - The Claims Data tab is updated with more detailed ICD-10 data, Non-Facility utilization data and additional subtabs for imaging and diagnostic services that have Professional Component/ Technical component split.
    - New Billed Together Data tab.
    - The PE Inputs tab is updated with a new aggregate direct PE costs table.
    - Many new advanced search and PE search capabilities.

- 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 meetings for the CPT 2023 cycle:
  - April 21-24, 2021 (virtual)
  - October 6-9, 2021 (location: Chicago, Illinois)
  - January 12-15, 2022 (location: San Diego, California)

## IV. Approval of Minutes from October 2020 RUC Meeting

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

## V. CPT Editorial Panel Update (Informational)

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

- **Panel Appointments**
  - Doctor Mark Synovec was reappointed as Chair of the CPT Editorial Panel, for a two-year term to expire in February 2023.
  - Doctor Christopher Jagmin was reappointed as Vice Chair of the CPT Editorial Panel, for a two-year term to expire in February 2023.
  - CMS asked to participate in the CPT Editorial Panel process in the role of non-voting observer, similar to the role it currently fulfills on the RUC.
  - To fill the vacated "CMS seat," the AMA BOT added an additional specialty society seat on the Panel. Doctor Timothy Swan, (former SIR Advisor) is now an active Panel member, with a four-year term.

- **Panel Meeting Activity in Response to COVID-19 Pandemic**
  - The Panel had nine special meetings so far this year for expedited approval of CPT codes for COVID-19 testing.
  - The Panel has approved three vaccine codes (91300, 91301, 91302) and six immunization administration codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A).
  - The Panel is currently reviewing an application for a single-dose administration product code. It will have a special CPT Panel meeting to consider approval within one to two weeks.
  - The RUC met on December 15-16, 2020 to draft RUC recommendation on work and PE inputs for the COVID-19 immunization administration codes (0001A, 0002A, 0011A, 0012A).
  - These updates to the CPT code set were published on the AMA's website following each meeting for immediate use in an effort to make them available as soon as possible during the public health emergency.

- **February 2021 CPT Editorial Panel Meeting**
  - The next virtual Panel meeting is February 4-6, 2021.
  - Doctor Doug Leahy will be attending the meeting as the RUC representative.
  - The next application submission deadline is November 4, 2020 for the February 2021 Panel meeting.
  - For the February 2021 Panel meeting, there are 41 agenda items. There are 3 digital medicine related CCAs, and 73 Category III codes being proposed for sundown.
  - For the February 2021 Panel meeting, 20 low utilization services are being presented and will be placed on the May 2021 agenda for actual deletion.
  - RUC referral to CPT – Tab 35 Orthoptic Training (revise 92065, add new code).
  - The annual CPT Advisory Committee will be held in conjunction with the virtual February 2021 Panel meeting.
  - Work continues to review the rest of the E/M sections other than the office visits.
  - The E/M Workgroup submitted seven comprehensive CPT Code Change Applications for the rest of the E/M visits to be reviewed at the February 2021 Panel meeting.

## VI. Centers for Medicare & Medicaid Services Update (Informational)

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

- **Rate-setting and Conversion Factor:**
  - The CY PFS Final Rule implemented a series of standard technical proposals involving practice expense, including the third year of the market-based supply and equipment pricing and standard rate-setting refinements to update premium data involving malpractice expense and GPCIs.
  - The final CY 2021 conversion factor is $34.89, a decrease of $1.20 from the CY 2020 PFS conversion factor of $36.09.

- **Medicare Telehealth**
  - In response to the public health emergency (PHE), CMS temporarily waived a number of these restrictions and adopted regulatory changes to expand access to Medicare telehealth.
  - Before the PHE, 14,000 patients received Medicare telehealth services in a week. During the PHE, nearly 12.8 million Medicare beneficiaries received telehealth services.
  - CMS added the following services to the Category I Medicare telehealth list:
    - Group Psychotherapy (90853)
    - Domiciliary, Rest Home, or Custodial Care Services, Established Patients (99334-99335)
    - Home Visits, Established Patient (99347-99348)
    - Cognitive Assessment and Care Planning Services (99483)
    - Prolonged Services (G2212)
    - Psychological and Neuropsychological Testing (96121)
  - CMS established two new HCPCS codes (G2010 and G2012) to facilitate billing for HCPAC practitioners for remote evaluation and patient-submitted video or images and virtual check-ins.
  - CMS finalized a frequency limitation for subsequent nursing facility telehealth visits of one visit every 14 days.

- **Remote Physiologic Monitoring (RPM) Services**
  - CMS clarified their payment policy related to the RPM services described in codes 99453, 99545, 99091, 99457, and 99458.
  - CMS clarified that only physicians and non-physician practitioners (NPPs) who are eligible to furnish E/M services may bill RPM services.

- **Direct Supervision Definition**
  - CMS finalized the definition that direct supervision may be provided using real-time, interactive audio and video technology through the end of the calendar year. The calendar year is defined as the PHE for COVID-19 ends or December 31, 2021.

- **Scope of Practice and Other Related Issues**
  - CMS finalized policy to allow supervision of diagnostic tests by certain NPPs.
  - CMS reiterated that pharmacists providing services incident to physician's professional services can be auxiliary personnel.
  - Policy was finalized that allows therapists the discretion to delegate the furnishing of maintenance therapy services.

- **Teaching Physicians and Resident Moonlighting Services**
  - Virtual presence
  - Primary Care Exception
  - Resident Moonlighting

- **Payment for Office/Outpatient E/M and Analogous Visits**

- In 2020, CMS finalized aligning E/M visit coding and documentation policies with modifications by the CPT Editorial Panel for office/outpatient E/M visits starting January 1, 2021. These coding and documentation policies include code redefinitions that rely on time or medical decision making, deletion of level 1 new patient code, and a new prolonged services code.
- CMS has also adopted revised medical decision making (MDM) guidelines adopted by the CPT Editorial Panel.
- Finalized separate payment for new HCPCS code G2212, to be reported in place of code 99417 to clarify the times for which prolonged office/outpatient E/M visits can be reported.

- **Opioid Use Disorder/Substance Use Disorder Provisions**
  - Policy was finalized to extend the definition of opioid use disorder (OUD) treatment services to include opioid antagonist medications.
  - Creation of new add-on code to cover cost of providing patients with nasal naloxone.
  - Creation of a second new add-on code to cover the cost of providing patients with injectable naloxone as contractor priced.
  - Policy was finalized that allows periodic assessments to be furnished via two-way, interactive audio-video communication technology.
  - CMS will be implementing Section 2022 of the Support Act: The Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) include substance use disorder (SUD) screenings and a review of any current opioid prescriptions.
  - To help inform CMS' implementation of Section 2003 of the Support Act, CMS has issued a RFI to further implement this provision in future rulemaking.

- **Changes Enacted by the Consolidated Appropriations Act, 2021**
  - The Consolidated Appropriations Act, 2021, was enacted on December 27, 2020 following the release of the CY 2021 Final Rule.
    - Provided a 3.75% increase in MPFS payments for 2021
    - Suspended 2% payment adjustment through March 31, 2021
    - Reinstated the 1.0 floor on the work GPCI through 2023
    - Delayed implantation of add-on code G2211 until 2024
    - These changes will result in increased in PFS payment amounts effective January 1, 2021.

## VII. Contractor Medical Director Update (Informational)

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

- **Work Groups Recap**
  - The workgroups chose LCD topics based on the need for clarification of a procedure, new technology or codes that require clarification.
  - The MAC ranked the procedure, technology and/or codes in order of priority to each jurisdiction and then chose the highest rank of importance across jurisdictions for collaboration.
  - Multi-MAC LCDs - MACs are learning to collaborate.
  - Many new multi-jurisdictional LCDs have been released or are in various stages of development.
  - Collaborative LCDs do not prevent the MACs from developing LCDs to meet the specific needs of their jurisdiction.

- **Advantages of Working Together**

- Allows for sharing of resources of specialty expertise and experience
- Data
- Access to different research problems, leveraging of combined work to produce more comprehensive and consistent results.

- **Disadvantages of Working Together**
  - Developing an LCD that most jurisdictions can agree to.
  - Diplomacy and willingness to compromise.
  - Each MAC has different levels of administrative procedures and restraints that affects timelines and deadlines.
  - Obtaining agreement may result in longer timetables to achieve a product.
  - Not all MACs participate in the process.

- **Results: Upcoming LCDs**
  - Facet LCD
  - Colon Capsule Endoscopy LCD
  - FFRCT LCD
  - MolDx Diagnostic Testing for Pathogens LCD
  - MolDx Minimal Residual Disease Testing for Cancer LCD
  - Epidural Interventions for Chronic Pain Management
  - Platelet Rich Plasma LCD

## VIII. Washington Update (Informational)

Jennifer McLaughlin, JD, Assistant Director of Federal Affairs, AMA, provided the Washington report focusing on the CY 2021 Medicare Physician Payment Schedule Final Rule.

- **Medicare Physician Payment Schedule – Final Rule**

  - Impact of COVID-19 Relief Legislation
    - Mitigated 10.2% budget neutrality cuts to the 2021 CF
      - CY 2021 CF: $34.8931, CY 2021 anesthesia CF: $21.56
    - Delayed implantation of add-on code G2211 until 2024.
    - Reinstated the 1.0 GPCI work floor until 2023.
    - Continued sequestration suspension until March 31, 2021.

  - Office and Outpatient E/M Services
    - CMS adopted CPT guidelines for reporting office and outpatient E/M services based on MDM or time to reduce unnecessary documentation.
    - CMS adopted RUC recommendations.
    - CMS did not adopt the RUC recommendation of visits bundled into global surgical payments.
    - CMS adopted G2212 as an add-on code.

  - COVID-19 Codes and Medicare Payment
    - The CPT Editorial Panel and RUC convened special meetings in 2020 to create numerous codes for COVID-19 testing, vaccines, immunization administration, and infection control practices.
    - CMS established interim final payments for COVID-19 vaccine administration codes. The AMA has advocated to immediately implement code 99072.

  - CY 2021 Final Rule
    - Remote Physiologic Monitoring (RPM)

- Clarified RPM codes are covered for patients with acute and chronic conditions.
- Medicare Diabetes Prevention Program (MDPP)
  - Plans are finalized to allow provision of the set of MDPP services virtually during any section 1135 declared PHE.

- Merit-Based Incentive Payment System
  - 2021 Changes
    - CMS has extended COVID-19 relief.
    - Postponed MIPS Value Pathways.
    - Increased performance threshold from 45 to 60 points to earn a bonus and avoid penalties.
    - Sunset MIPS APM scoring standard and adopted new APP measure set.
  - 2020 Relief
    - Hardship exception applications harmless from any MIPS penalty during the PHE due by February 1, 2021.

- COVID-19 Relief Legislation
  - CARES Act Provider Relief Fund: $3 billion.
  - Two-year freeze of Advanced APM payment incentive thresholds.
  - Graduate Medical Education.
  - Expands access to mental health services through telehealth.
  - Waives Medicare coinsurance for certain colorectal cancer screening tests.
  - Surprise Medical Billing: provides patient protections from out-of-network bills.
  - Rural Health: implantation of Rural Health Clinic (RHC) payment reform plan.

- COVID-19 Public Health Emergency
  - Vaccine Distribution
    - Combatting vaccine hesitancy
  - Distribution programs
  - Regulatory Relief
  - Personal Protective Equipment (PPE)
  - COVID-19 Testing: working with pathology/laboratory colleagues on testing policy/supply chain issues

## IX. Relative Value Recommendations for *CPT 2022*

**<u>Anesthesia Services for Image-Guided Spinal Procedures - Tab 4</u>**
**Neal Cohen, MD (ASA), Gordon Morewood, MD, MBA (ASA) and Richard Rosenquist, MD (ASA)**

In 2017, the RUC identified CPT code 01936 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic* via the high volume growth screen. The Relativity Assessment Workgroup reviewed data on what procedures are reported with this anesthesia code. The Workgroup noted it was concerned that this service may be reported inappropriately, as the top surgical services reported with 01936 utilization did not show significant increases and some of these services indicate that moderate sedation is included. The Workgroup noted that the specialty society provided significant education on the correct reporting of this service, however, it can not reach all providers of this service or physicians who request the anesthesia service. The Workgroup recommended reviewing 01936 after two years of utilization data were available including the utilization for the top surgical services reported with 01936. In October 2019, the Workgroup reviewed this service and recommended that it be referred to CPT to create more granular codes. In October 2020, the CPT Editorial Panel replaced 01935 and 01936

with six new codes to report percutaneous image-guided spine and spinal cord anesthesia procedures and revised a parenthetical following code 00600 to refer to these newly created CPT codes.

**Drainage/Aspiration**

**01937** ***Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic***
The RUC reviewed the survey results from 41 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 8 minutes post-anesthesia evaluation, totaling 42 minutes.

The majority of survey respondents indicated that the intensity and complexity measures for 01937 are identical to somewhat more intense than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which support the base unit recommendation. In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01937 aligns appropriately with the regression line, which supports the recommended base unit.

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01937 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01937**.

**01938** ***Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral***
The RUC reviewed the survey results from 44 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 8 minutes post-anesthesia evaluation, totaling 42 minutes.

The majority of survey respondents that selected each of the corresponding top two key reference services indicated that the intensity and complexity measures for 01938 are identical to somewhat more intense and complex than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which support the base unit recommendation. In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01938 aligns appropriately with the regression line, which supports the recommended base unit. The RUC agreed with the survey respondents that these anesthesia for percutaneous image-guided injection drainage or aspiration procedures are the same whether they are performed in the cervical/thoracic (01937) or lumbar/sacral areas (01938).

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01938 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01938**.

**Destruction**

**01939** ***Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic***

The RUC reviewed the survey results from 40 anesthesiologists and determined that a base unit of 4 appropriately accounts for the work required to perform this service. The RUC noted that the survey 25th percentile and median were both a base unit of 5. However, RUC determined that the anesthesia for percutaneous image-guided destruction by neurolytic agent procedures are the same whether they are performed in the cervical/thoracic (01939) or lumbar/sacral areas (01940), the same as the injection or aspiration services 01937 and 01938.

The RUC recommends 11 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 45 minutes. The RUC recommends for 01939 to have a direct base unit crosswalk to the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4 and 50 minutes total time), thus maintaining the appropriate relativity with 01937, 01938 and 01940, all with a base unit of 4. CPT code 01939 and 00142 are similar anesthesia services both requiring similar precision. The surveyed code requires precision in the tight cervical area with little movement to prevent injury and CPT code 00142 requires precision regarding delicate surgeries to the lens to avoid injury.

The majority of survey respondents indicated that the intensity and complexity measures for 01939 are identical to somewhat more intense than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which bracket the base unit recommendation.

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01939 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01939**.

**01940** ***Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral***

The RUC reviewed the survey results from 41 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to perform this service. The RUC recommends 11 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 45 minutes.

The majority of survey respondents that selected each of the corresponding top two key reference services indicated that the intensity and complexity measures for 01940 are identical to somewhat more intense than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which support the base unit recommendation. In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01940 aligns appropriately with the regression line, which supports the recommended base unit. The RUC determined that that the anesthesia for percutaneous image-guided destruction by neurolytic agent procedures are the same whether they are performed in the cervical/thoracic (01939) or lumbar/sacral areas (01940), the same as the injection or aspiration services codes 01937 and 01938.

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01940 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01940**.

**Neuromodulation**

**01941** ***Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic***
The RUC reviewed the survey results from 47 anesthesiologists and determined that a base unit of 6 appropriately accounts for the work required to perform this service. The RUC recommends 13 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 8 minutes intra-operative anesthesia induction period, 20 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 48 minutes. The RUC noted that the survey median of 7 base units was a bit high and the survey 25$^{th}$ percentile of 5 base units was a bit low compared to other anesthesia services. The RUC noted that the anesthesia reference service list does not contain any services with 6 base units, which reduces the likelihood of a survey respondent estimating 6 base units versus either 5 or 7 base units. Therefore, the RUC recommends that 01941 be crosswalked to 00732 *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)* (base unit = 6).

In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01941 aligns appropriately with the regression line, which supports the recommended base unit. The RUC determined that that the anesthesia for percutaneous image-guided neuromodulation procedures is the same whether they are performed in the cervical/thoracic (01941) or lumbar/sacral areas (01942), the same as the comparison between the other services in this family.

The specialty society indicated and the RUC agreed that 01941 and 01942 require a more complex anesthetic technique to protect the patients while in the prone position. This position takes extra care prior to the start of the procedure to ensure the airway is properly secured. During the procedure, the patient is unable to protect their own airway, causing the potential for significant complications and requires constant monitoring. Additionally, spinal procedures performed in the prone position cause additional pressure points for the anesthetist to monitor throughout the procedure. These risks and added complexities exist for these procedures performed on the spine.

The complexity of the service, the added comorbidities of the typical patient, and the required constant monitoring of the patient in the prone position support the 6 base unit recommendation for CPT code 01941. **The RUC recommends a base unit of 6 for CPT code 01941**.

**01942** ***Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral***
The RUC reviewed the survey results from 49 anesthesiologists and determined that a base unit of 6 appropriately accounts for the work required to perform this service. The RUC recommends 13 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 8 minutes intra-operative anesthesia induction period, 20 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 48 minutes. The RUC noted that the survey median of 7 base units was a bit high and the survey 25$^{th}$ percentile of 5 base units was a bit low compared to other anesthesia services. The RUC noted that the anesthesia reference service list does not contain any services with 6 base units. Therefore, the RUC recommends that 01942 be crosswalked to 00732 *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)* (base unit = 6).

In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01941 aligns appropriately with the regression line, which supports the recommended base unit. The RUC determined that the anesthesia for percutaneous image-guided neuromodulation procedures is the same whether they are performed in the cervical/thoracic (01941) or lumbar/sacral areas (01942), the same as the comparison between the other services in this family.

The specialty society indicated, and the RUC agreed that 01941 and 01942 require a more complex anesthetic technique to protect the patients while in the prone position. This position takes extra care prior to the start of the procedure to ensure the airway is properly secured. During the procedure, the patient is unable to protect their own airway, causing the potential for significant complications and requires constant monitoring. Additionally, spinal procedures performed in the prone position cause additional pressure points for the anesthetist to monitor throughout the procedure. These risks and added complexities exist for procedures performed on the spine.

The complexity of the service, the added comorbidities of the typical patient, and the required constant monitoring of the patient in the prone position support the 6 base unit recommendation for CPT code 01942. **The RUC recommends a base unit of 6 for CPT code 01942**.

**Practice Expense**
**The RUC recommends the anesthesia standard of eight minutes for clinical staff pre-time for the entire family of 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.

## Closed Treatment of Nasal Bone Fracture - Tab 5

**Jeffrey Kozlow, MD (ASPS), R. Peter Manes, MD (AAO-HNS) and Ari Wirschafter, MD (AAO-HNS)**

In October 2020, the CPT Editorial Panel deleted code 21310 and revised two codes to add "with manipulation" to their CPT long descriptors and added a parenthetical to report the appropriate Evaluation and Management (E/M) code for closed treatment of nasal bone fracture without manipulation.

**Compelling Evidence**

The RUC reviewed and agreed that there is compelling evidence to recommend an increase in value for CPT codes 21315 *Closed treatment of nasal bone fracture with manipulation; without stabilization* and 21320 *Closed treatment of nasal bone fracture with manipulation; with stabilization* based on evidence that flawed methodology was used in the previous valuation and there was a change in the dominant specialty performing these services. Specifically, based on the 1991 Federal Register, these codes were assigned work values based on "physician work value[s] established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors." This may explain why code 21315 currently has a negative IWPUT and demonstrates that a flawed methodology was used in the previous valuation as there is a discrepancy between this information and data provided by the AMA which indicates a Harvard phase 4 study was done for each code, resulting in 19 responses for code 21315 and 103 responses for code 21320. The RUC agreed that compelling evidence is met from a flawed methodology used in the previous valuation. Additionally, for codes 21315 and 21320, there has been a change in specialty from oral maxillofacial surgery to now otolaryngology and plastic surgery. **The RUC agreed that there is compelling evidence that there has been a change in the dominant specialty as well as evidence that flawed methodology was used in the previous valuation of these services.**

**Change in Global Period**
It is no longer typical to see the patient within 10 days post-procedure. There is little to be gained by examination prior to that given the degree of swelling which can often obscure the final result. For code 21320, the splint can either be removed after 10 days or removed by the patient at home, again not requiring a visit within 10 days post-procedure. The RUC agreed with the global period change from 010-day to 000-day global.

**21315 *Closed treatment of nasal bone fracture with manipulation; without stabilization***
The RUC reviewed the survey results from 191 otolaryngologists and plastic surgeons and determined that the survey 25th percentile work RVU of 2.00 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 15 minutes of intra-service time, and 10 minutes of immediate post-service time.

The RUC compared the survey code to the second top key reference code 31574 *Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral* (work RVU= 2.43, intra-service time of 15 minutes and total time of 55 minutes) and noted that both codes have identical intra-service time and should be valued similarly however, the survey code has 13 more minutes of total time. Many survey respondents (44%) that selected code 31574 rated the survey code more intense/complex than the second top key reference service, further warranting the recommended work value. Additionally, the RUC compared the survey code to code 15040 *Harvest of skin for tissue cultured skin autograft, 100 sq cm or less* (work RVU= 2.00, intra-service time of 15 minutes and total time of 60 minutes) and noted that both codes require the same intra-service time and similar total time justifying the recommended survey 25th percentile work value of 2.00. **The RUC recommends a work RVU of 2.00 for CPT code 21315.**

**21320 *Closed treatment of nasal bone fracture with manipulation; with stabilization***
The RUC reviewed the survey results from 219 otolaryngologists and plastic surgeons and determined that the survey 25th percentile work RVU of 2.33 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 20 minutes of intra-service time, and 12 minutes of immediate post-service time.

The RUC compared the survey code to the top key reference code 43191 *Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)* (work RVU= 2.49, intra-service time of 20 minutes and total time of 86 minutes) and noted that both codes have identical intra-service time. Although the top key reference code has 11

more minutes of total time, most survey respondents (68%) that selected this top key reference code also rated the survey code more intense/complex than the top key reference service. Additionally, the RUC compared the survey code to code 43204 *Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices* (work RVU= 2.33 and intra-service time of 20 minutes) and agreed that both codes require the same intra-service time and amount of physician work. **The RUC recommends a work RVU of 2.33 for CPT code 21320.**

**Practice Expense**
The Practice Expense Subcommittee removed SG066 *packing, gauze w-petrolatum, 0.5in (6yd uou)* and CA014 *Confirm order, protocol exam* as it was determined that, while the code is done with imaging present, imaging is not being done at that time. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**<u>Arthrodesis Decompression – Tab 6</u>**
**William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Morgan Lorio, MD (ISASS), Eric Mayer, MD (NASS), 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 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 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with 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 codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, do we have assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. **The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 and 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053.**

**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 141 neurosurgeons and orthopaedic surgeons and determined that the survey 25$^{th}$ percentile work RVU of 5.55 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 40 minutes intra-service time.

To justify a work RVU of 5.55, the RUC compared the survey code to the second key reference service code 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 and

45 minutes intra-service time) and noted that the reference code has slightly higher intensity as anticipated for a surgical procedure as compared with a lumbar procedure. 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 and 40 minutes intra-service 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, although both codes require the same time, the physician work and intensity of 63052 is greater than 34812.

For additional support, the RUC agreed that CPT code 63052 is appropriately bracketed by comparator codes 33924 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)* (work RVU = 5.49 and 30 minutes intra-service time) and 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 and 40 minutes intra-service time). CPT code 33924 takes less time but is significantly more intense than 63052, while the time and physician work for CPT code 22614 is like 63052. The RUC concluded that CPT code 63052 should be valued at the 25$^{th}$ percentile work RVU as supported by the survey. **The RUC recommends an interim work RVU of 5.55 for CPT code 63052.**

**63053 *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 141 neurosurgeons and orthopaedic surgeons and determined that a direct work RVU crosswalk to CPT code 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44 and 30 minutes intra-service time) accurately reflects the physician work necessary for this add-on service and falls below the survey 25$^{th}$ percentile. The RUC acknowledged the robust survey results yet questioned the 25$^{th}$ percentile value given the time for CPT code 63053 is three-fourths that of the 63052 code.

The RUC 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 and 40 minutes intra-service time) and noted that the MPC code involves more intra-service time and the physician work and intensity are greater for the survey code.

For additional support, the RUC agreed that CPT code 63053 is appropriately bracketed by comparator codes 32674 *Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)* (work RVU = 4.12 and 30 minutes intra-service time) and 33924 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)* (work RVU = 5.49 and 30 minutes intra-service time). CPT code 32674 is a minimally invasive procedure to identify and remove lymph nodes in conjunction with a single lobe lobectomy. The technical skill and mental effort/judgment for 63053 is greater due to the involvement and protection of spinal cord and neural elements. CPT code 33924 requires the same amount of time but is more intense than 63053.
The RUC concluded that CPT code 63053 should be valued based on a direct crosswalk to CPT code 33572 with 30 minutes intra-service time as supported by both the crosswalk and the survey. **The RUC recommends an interim work RVU of 4.44 for CPT code 63053.**

**Practice Expense**
No direct practice expense inputs are recommended for CPT codes 63052 and 63053 as they are facility-based add-on services.

**RUC Database Flag**
The RUC recommends to flag CPT codes 63052 and 63053 as "Do Not Use to Validate for Physician Work" since the values are being assigned on an interim basis.

**Percutaneous Cerebral Embolic Protection – Tab 7**
**Lloyd Klein, MD (SCAI), Edward Toggart, MD (SCAI), Edward Tuohy, MD (ACC), Thad Waites, MD (ACC) and Richard Wright, MD (ACC)**

In October 2020, the CPT Editorial Panel created a new add-on code to report transcatheter placement and subsequent removal of cerebral embolic protection device(s) and added instructions to report the new code in the Aortic Valve guidelines.

**33370** ***Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 35 interventional cardiologists and agreed that the survey respondents, with a 25th percentile work value of 3.43, overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT 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, intra-service and total time of 20 minutes) would be appropriate, as both add-on services typically involve an identical amount of time and physician work intensity to perform. The RUC recommends 20 minutes of intra-service time.

The specialties noted that this new CPT code represents new technology enabling the capture and removal of debris that can dislodge during TAVR procedures. During the TAVR procedure, dislodged embolic debris may include pieces of arterial wall, valve tissue, calcified and foreign material, and both acute and organizing thrombus. Even small pieces can block blood flow to middle cerebral arteries and more distal tributaries in the brain, potentially leading to peri-procedural (≤ 72 hours) stroke or other neurological impairments, with devastating long-term consequences. Code 33370 includes percutaneous arterial (eg, right radial or femoral) access, placement of a guiding catheter, and delivery of the embolic protection filter(s) prior to the procedure. Placement of additional/multiple filters is not separately reportable. Code 33370 includes removal of the filter(s) and debris, removal of the arterial sheath, and closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture, as well as all imaging guidance and radiological supervision and interpretation associated with performing the service.

The specialties noted that unlike the underlying TAVR procedure that would be performed by a co-surgeon team (an interventional cardiologist and a cardiac surgeon), the transcatheter placement and subsequent removal of a cerebral embolic protection device would only be performed and reported by one provider, the interventional cardiologist. Therefore, this service would not be reported with the 62 co-surgeon CPT modifier.

The specialties also noted, and the RUC concurred, that this is an intense service to perform. The specialties noted that positioning and deploying the filters and retrieving them under fluoroscopy is very intense work for the interventional cardiologist as, during this time, trauma from the device itself could potentially dislodge debris causing stroke which it was intended to prevent.

Furthermore, the specialties confirmed that placement of additional/multiple filters is not separately reportable.

For additional support for a work value of 2.50, the RUC compared the survey code to MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09 and intra-service time of 15 minutes) and noted that the survey code involves 5 more minutes of intra-service time and both services involve similar intensity. **The RUC recommends a work RVU of 2.50 for CPT code 33370.**

**Affirmation of RUC Recommendations**
CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 were surveyed in April 2018 and approved by CMS for the CPT 2020 cycle. Add-on codes 33367, 33368 and 33369 were surveyed in February 2012 and approved by CMS for the CPT 2013 cycle; these three services had their values affirmed by the RUC and CMS for the CPT 2020 cycle. The specialties noted that the new cerebral embolic protection service does not alter the underlying work of the TAVR. The RUC noted that the times, work values and direct PE inputs for these existing services continue to be appropriate. **The RUC affirms the work RVU of 22.47 for CPT code 33361, the work RVU of 24.54 for CPT code 33362, the work RVU of 25.47 for CPT code 33363, the work RVU of 25.97 for CPT code 33364, the work RVU of 26.59 for CPT code 33365, the work RVU of 29.35 for CPT code 33366, the work RVU of 11.88 for CPT code 33367, the work RVU of 14.39 for CPT code 33368 and the work RVU of 19.00 for CPT code 33369.**

**Practice Expense**
**The RUC affirms the direct practice expense inputs for CPT codes 33361-33369.** No direct practice expense inputs are recommended for CPT code 33370 as it is a facility-based add-on service.

**New Technology/New Service**
The RUC recommends that 33370 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Endovascular Repair of Aortic Coarctation – Tab 8**
**Sergio Bartakian, MD (SCAI); Edward Toggart, MD (SCAI), Edward Tuohy, MD (ACC); Thad Waites, MD (ACC) and Richard Wright, MD (ACC)**

In October 2020, the CPT Editorial Panel created two codes to report endovascular stent repair of coarctation of the thoracic or abdominal aorta and one code to report trans-liminal angioplasty for repair of native or recurrent percutaneous coarctation of the aorta.

**33894** ***Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches***
The RUC reviewed the survey results from 41 interventional and pediatric interventional cardiologists and recommends 60 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 134 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, unlike codes 33895 and 33897, the pre-service evaluation work for 33894 includes evaluation using a 3D-printed model of the heart which requires additional pre-service evaluation time. The specialties also noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC reviewed both the survey 25$^{th}$ percentile work RVU of 18.27 and survey median work value of 23.30 and agreed that the appropriate value for this service should be between the 25$^{th}$ percentile and the

median value. The RUC agreed that a direct work value crosswalk to CPT code 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, intra-service time of 135 minutes, total time of 223 minutes) and noted that both services involve nearly the same amount of intra-service time (134 minutes vs. 135 minutes) and the same overall amount of physician work. The RUC also compared the survey code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180, total time of 270) and noted that the reference code involves more total time yet less intra-service time. The RUC also noted that 75 percent of the survey respondents that selected the top key reference code had rated the survey code as more intense and complex to perform. A value of 21.70, would appropriately value this survey code at a lower work value, yet somewhat higher intensity than the survey code, given the differences in intra-service time and intensity between the two services. **The RUC recommends a work RVU of 21.70 for CPT code 33894.**

**33895** ***Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; not crossing major side branches***
The RUC reviewed the survey results from 41 interventional and pediatric interventional cardiologists and recommends 50 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC reviewed both the survey 25$^{th}$ percentile work RVU of 15.00 and survey median work value of 20.00 and agreed that the appropriate value for this service should be between the 25$^{th}$ percentile and the median value. The RUC agreed that a direct work value crosswalk to CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU= 17.97, intra-service time of 120 minutes, total time of 208 minutes) and noted that both services involve an identical amount of intra-service time. The RUC also compared the survey code to second 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 the same amount of intra-service time and the same overall amount of physician work. **The RUC recommends a work RVU of 17.97 for CPT code 33895.**

**33897** ***Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta***
The RUC reviewed the survey results from 41 interventional and pediatric interventional cardiologists and recommends 50 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC reviewed both the survey 25$^{th}$ percentile work RVU of 12.00 and survey median work value of 17.00 and agreed that the appropriate value for this service should be between the 25$^{th}$ percentile and the

median value. The RUC agreed that a direct work value crosswalk to CPT 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 both services involve an identical amount of intra-service time and overall amount of physician work. The RUC also compared the survey code to CPT code 33988 *Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS* (work RVU= 15.00, intra-service time of 90 minutes, total time of 250 minutes) and noted that although both services involve an identical amount of intra-service time, the reference code involves 10 more minutes of total time. **The RUC recommends a work RVU of 14.00 for CPT code 33897.**

**Practice Expense**
**No direct practice expense inputs are recommended for CPT codes 33894, 33895 and 33897 as they are facility-only services.**

**Tracking CPT Code Changes that Will Impact 33894**
The RUC noted that its recommendation for CPT code 33894 includes pre-service evaluation work for evaluation using a 3D-printed model of the heart which requires additional pre-service evaluation time. If a CPT code is created in the future which would enable this service to be separately reported, then 33894 should be re-reviewed.

**Harvest of Upper Extremity Artery, Endoscopic and Open – Tab 9**
**Stephen Lahey, MD (AATS), James Levett, MD (STS), Francis Nichols, MD (STS), Folusho Ogunfiditimi, PA-C (AAPA), Jacob Schroder, MD (STS), Joseph Turek, MD (STS), Prashanath Vallabhajosyula, MD (STS) and Korinne Van Keuren, DNP, MS, RN (ANA)**

In May 2020, the CPT Editorial Panel created CPT code 33509 harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic to describe endoscopic radial artery harvest via an endoscopic approach and CPT code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open* was modified to only include an open approach for the upper extremity harvesting procedure.

At the October 2020 RUC meeting, the specialty societies explained that the rationale for assigning these services an XXX global period instead of a ZZZ, even though the service is almost exclusively performed in conjunction with an arterial coronary artery bypass grafting (CABG) procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their National Provider Identifier (NPI) number. It was noted that it is often a Nurse Practitioner (NP) or Physician's Assistant (PA) who performs the harvest procedure. The RUC agreed that since NPs and PAs were not included in the survey sample for the October 2020 meeting survey process, it would be appropriate to assign 33509 and 35600 interim values and to request for them to be resurveyed for the January 2021 RUC meeting to include these providers who are potentially the dominant providers.

During their January 2021 presentation, the specialty societies noted that the radial artery is typically used in situations where a patient is undergoing a re-operative CABG procedure where the intrathoracic arteries have already been used and/or in patients with limited saphenous vein conduit available due to prior use in peripheral vascular disease operations or use in a previous CABG procedure. Recent studies appear to indicate that use of radial-artery grafts for CABG may result in better postoperative outcomes than the use of saphenous-vein grafts. As a result of these circumstances, use of the radial artery in CABG has been increasing. Originally the radial artery was harvested using an open technique, but with technological advances, it is now possible to harvest the radial artery using an endoscopic technique and this method of harvest, where available, is now the preferred method for harvesting the radial artery.

**33509** ***Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic***

The RUC reviewed the specialty societies' recommended work RVU at the survey 25th percentile of 3.75 from 84 cardiothoracic surgeons, cardiothoracic and cardiovascular surgical physician assistants and nurse practitioners, and concurred that the survey respondents appropriately valued the work involved in performing this service. The RUC recommends an intra-service time of 35 minutes for CPT code 33509.

The specialty societies explained the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI number.

To justify a value of 3.75, the RUC compared the survey code to CPT code 36228 *Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)* (work RVU= 4.25 and intra-service time of 30 minutes) and noted that although the reference code includes less physician time, it is a relatively more intense service to perform, supporting a somewhat lower value for the survey code. The RUC also compared the survey code to CPT code 22512 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)* (work RVU= 4.00, intra-service time of 30 minutes, total time of 32 minutes) and noted that the survey code involves somewhat more intra-service and total time but is slightly less intense to perform, supporting a work value of 3.75 for the survey code. **The RUC recommends a work RVU of 3.75 for CPT code 33509.**

**35600** ***Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open***
The RUC reviewed the specialty societies' recommended work RVU at the survey 25th percentile of 4.00 from 72 cardiothoracic surgeons, cardiothoracic and cardiovascular surgical physician assistants and nurse practitioners, and concurred that the survey respondents appropriately valued the work involved in performing this service. The RUC recommends intra-service time of 40 minutes for CPT code 35600. The specialties explained that the open approach for harvesting an upper extremity artery involves somewhat more time relative to the endoscopic approach.

The specialty societies explained that the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI number.

The RUC 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, intra-service and total time of 40 minutes) and noted that both services involve an identical amount of time and are both major surgical procedure add-on services for accessing an artery via an open approach. The RUC also compared the survey code to CPT code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service and total time of 40 minutes) and noted that both services involve identical times. **The RUC recommends a work RVU of 4.00 for CPT code 35600.**

**Practice Expense**
No direct practice expense inputs are recommended for CPT codes 33509 and 35600 as they are facility-only services.

**Modifier-51 Exempt Status**
CPT codes 33509 and 35600 are recommended to be placed on the Modifier -51 Exempt list, as these services are performed a large majority of the time with a coronary artery bypass procedure, though typically it is a separate provider (such as an NP or PA) that is performing the harvest of upper extremity artery procedure and therefore would be reporting 33509 or 35600 as a standalone code on a separate claim.

**New Technology**
CPT codes 33509 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.

**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.

**RUC Database Flag**
CPT codes 35600 and 33509 are performed a large majority of the time with a coronary artery bypass procedure, though typically it is a separate provider (such as an NP or PA) that is performing the harvest of upper extremity artery procedure and therefore would be reporting 33509 or 35600 as a standalone code on a separate claim. Due to this, these services were valued like add-on codes, though can be separately reported and may include some physician work related to patient evaluation within the intra-service time. The RUC notes that they should be flagged as "**Do not use to validate for physician work."**

**<u>Drug Induced Sleep Endoscopy (DISE) – Tab 10</u>**
**R. Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)**

In October 2020, the CPT Editorial Panel created one new code to report drug induced sleep endoscopy (DISE) flexible, diagnostic.

**42975** ***Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and largynx for evaluation of sleep disordered breathing; flexible, diagnostic***
The RUC reviewed the survey results from 148 otolaryngologists and determined that the survey 25$^{th}$ percentile work RVU of 1.90 accurately reflects the typical physician work necessary 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 28 minutes of immediate post-service time.

To justify the 28 minutes of immediate post-service time, the specialty society explained that the typical patient has significant sleep apnea and has had their airway manipulated. After receiving sedation and scoping of the upper airway, the airway is no longer secure and must be monitored. Often patients must be monitored closely following the procedure until the patient is discharged from the hospital. Nonetheless, physician work continues outside of the immediate post-operative time for potentially increased swelling and/or because the patient's sedation has not worn-off. However, the RUC questioned the ½ discharge day management (99238), resulting from the specialty society using a 000-day global instrument with post-operative visits to value the service. The RUC agreed that the 000-day global survey instrument with post-operative visits is not typical and is dedicated for services that require more significant hospital stay. After thorough discussion, the RUC agreed that a ½ discharge day management (99238) is not necessary for this service. By surveying the incorrect 000-day global survey instrument, survey respondents underestimated the immediate post-service time estimates. The RUC agreed with an immediate post-service time of 28 minutes with the understanding that there is time value related to the ½ discharge day management originally recommended by the specialty society and agreed that post-service time package (8b) of 28 minutes is justified. The RUC requested that this service be valued as interim and

be resurveyed for the April 2021 RUC meeting using a standard 000-day global survey instrument (*without* post-operative visits).

The RUC compared the survey code to code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 1.90 and intra-service time of 15 minutes) and noted that both codes have identical intra-service time and should be valued identically. Additionally, the RUC compared the survey code to 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 and intra-service time of 15 minutes) and noted that both codes require the same amount of physician work and intra-service time, further warranting a value of 1.90. **The RUC recommends an interim work RVU of 1.90 for CPT code 42975.**

**RUC Database Flag**
The RUC recommends to flag CPT code 42975 as "do not use to validate for physician work" since the RUC is recommending an interim work RVU for this service and will be resurveyed for the April 2021 RUC meeting.

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

**<u>Periurethral Balloon Continence Device Procedures – Tab 11</u>**
**Jon Kiechle, MD (AUA); Drew Peterson, MD (AUA), Kyle Richards, MD (AUA) and Thomas Turk, MD (AUA)**

In October 2020, the CPT Editorial Panel replaced four CPT Category III codes (0548T, 0549T, 0550T, and 0551T) with four new CPT Category I codes (53451, 53452, 53453, 53454) to report periurethral adjustable balloon continence device. The RUC reviewed a letter from the American Urological Association that noted that these codes currently have low utilization and that only 65 physicians have been trained to perform these procedures; only 38 of those physicians have performed them. Given the low utilization and the low survey response rate (four completed survey responses), the specialty society recommended that CMS have the Medicare Administrative Contractors (MACs) contractor price these procedures. **The RUC recommends contractor pricing CPT codes 53451, 53452, 53453, and 53454**.

**New Technology**
CPT codes 53451, 53452, 53453, and 53454 will be placed on the New Technology list and be re-reviewed by the RUC in two years to ensure correct valuation and utilization assumptions.

**<u>Intracranial Laser Interstitial Thermal Therapy – Tab 12</u>**
**John Ratliff, MD (AANS), Joshua Rosenow, MD (AANS) and Clemens Schirmer, MD (CNS)**

In October 2020, the CPT Editorial Panel approved the addition of two codes to report laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance (MR) imaging guidance for a single trajectory for 1 simple lesion and multiple trajectories for multiple or complex lesion(s). LITT is a novel procedure that involves multiple steps and movements of the patient through the hospital for different stages of the procedure. The typical facility does not have an interoperative MRI suite (small minority of academic medical centers may), so patient transport is necessary.

**61736** ***Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion***

The RUC reviewed the survey results from 48 neurosurgeons and determined that the survey median work RVU of 20.00 appropriately accounts for the physician work required to perform this service. The RUC recommends the physician times as supported by the survey: 113 minutes pre-service time (68 minutes evaluation, 30 minutes positioning, 15 minutes scrub/dress/wait time), 180 minutes intra-service time, and 60 minutes immediate post-service time. Though the median survey post-service time was 40 minutes, the CMS 23-hour stay policy was applied resulting in 60 minutes.

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 codes. 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 these codes to include bundle subsequent hospital visits (eg 99231-99233) into the surgical global period. 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. The RUC noted that the survey codes have 000-day global periods which typically do not allow for an Evaluation and Management (E/M) visit on the same day as the procedure. 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).

The RUC noted that close monitoring during the first 12-24 hours after brain surgery is critical to a successful outcome. One hundred percent of the survey respondents indicated that a visit would be required later the same day of the procedure. The median response for level of visit was 99232. Therefore, the final immediate post-service time recommended is 60 minutes = 33 (post-service time package 9b) + 7 (additional time related to hardware removal and documentation) + 20 (post-operative visit intra-service time).

The RUC also noted that the pre-service time is appropriate due to the imaging that occurs as part of the pre-service evaluation time. Preoperative MRI volumetric planning is performed just prior to the procedure. Planning for the procedure and coordination with the healthcare delivery team add a significant amount of time to the work typically assigned to pre-service time package 4. In addition, the RUC specifically inquired about the transfer time for the MRI that occurs within the intra-service period. This was described as a high intensity, sterile transport within the confines of a surgical procedure, with care to protect the laser assembly and anchor bolt, with the surgeon engaged the entire time.

To justify a work RVU of 20.00, the RUC compared CPT code 61736 to the two key reference service codes 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU = 15.00, 100 minutes intra-service time and 241 minutes total time) and 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU = 12.32, 90 minutes intra-service time and 233 minutes total time) and noted that although the codes all require intracranial work, intraoperative imaging and significant postoperative care, the survey code has much greater intra-service and total times. Neither codes 61645 nor 61640 include the significant preoperative evaluation and positioning time required for 61736. The survey code was considered more intense/complex overall by 84% of survey respondents that selected the top key reference code and 100% of respondents who selected the second key reference code. The RUC recognized that the survey was constrained by a dearth of 000-day global codes familiar to neurosurgeons, making comparison using magnitude estimation difficult. Similarly, there are many MPC codes with a 000 global assignment, but none that approach the work required of CPT code 61736.

For additional support, the RUC agreed that 61736 is appropriately bracketed by comparator codes 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 intra-service time and 323 minutes total time) and 33977 *Removal of ventricular assist device; extracorporeal, single ventricle* (work RVU = 20.86, 180 minutes intra-service time and 335

minutes total time) and noted that all three codes require significant pre- and post-service work on the day of the procedure and have the same or similar intra-service time and intensity. The RUC concluded that CPT code 61736 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 20.00 for CPT code 61736.**

**61737** ***Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)***
The RUC reviewed the survey results from 44 neurosurgeons and determined that the survey median work RVU of 24.00 appropriately accounts for the physician work required to perform this service. The RUC noted that compared to patients undergoing LITT for a single lesion, the complexity of CPT code 61737 and the level of patient instability and risk is greater. At present, the typical number of "multiple" trajectories is two, thus in many aspects the physician work is doubled. After robust discussion, the RUC recommends the physician times as supported by the survey: 144 minutes pre-service time (93 minutes evaluation, 36 minutes positioning, 15 minutes scrub/dress/wait time), 235 minutes intra-service time, and 40 minutes immediate post-service time and 1-99233 office visit. The RUC noted that these codes have 000-day global periods which typically do not allow for an E/M visit on the same day as the procedure. However, unlike code 61736, CPT code 61737 typically involves a full 2-midnight admission, as reflected by the survey respondents, which justifies the same-day E/M visit.

To justify a work RVU of 24.00, the RUC compared CPT code 61737 to the top key reference service code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU = 15.00, 100 minutes intra-service time and 241 minutes total time) and noted that although both codes require intracranial work, intraoperative imaging and significant postoperative care, the reference code requires less intra-service and total time and less positioning time. However, the key reference code 61645 was chosen most often (75%) by survey respondents and is the highest valued code on the reference service list. There are many MPC codes with a 000 global assignment, but none that approach the work required of 61737.

For additional support, the RUC concurred that 61737 is appropriately bracketed by comparator codes 93656 *Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation* (work RVU = 19.77, 240 minutes intra-service time and 309 minutes total time), typically performed as an outpatient procedure in a catheterization lab, and 33976 *Insertion of ventricular assist device; extracorporeal, biventricular* (work RVU = 30.75, 240 minutes intra-service time and 455 minutes total time) and noted that all three codes require similar intra-service time. The RUC concluded that CPT code 61737 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 24.00 for CPT code 61737.**

**Practice Expense**
The Practice Expense Subcommittee accepted the request of the specialties for standard 90-day global preclinical staff times. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

**New Technology**
CPT codes 61736 and 61737 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.

**<u>Hypoglossal Nerve Stimulator Services – Tab 13</u>**
**R. Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)**

In October 2020, the CPT Editorial Panel replaced three CPT Category III codes with three new CPT Category I codes to report open implantation, revision or replacement, and removal of hypoglossal nerve stimulator array. In addition, the CPT Editorial Panel made editorial revisions to codes 64568, 64569, 64570, 64575, 64580, and 64581.

**64582** ***Open implantation of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array***
The RUC reviewed the survey results from 89 otolaryngologists and determined that the survey median work RVU of 16.00 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 20 minutes of pre-service positioning time, 14 minutes of pre-service scrub/dress/wait time, 140 minutes of intra-service time, 20 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213). The RUC agreed that the recommended 20 minutes of positioning time, an increase of 17 minutes from pre-time package 4, is consistent with the survey median time and necessary for this procedure. Specifically, the chest area must be taped down to access the neck and utilize sleds and belts to secure them. There are two specific surgical sites and patients typically have very large/obese (BMI > 30) body habitus. Positioning requires the physician to access and position the patient in an ergonomic fashion and requires extended neck and chest access throughout the procedure. Additionally, the RUC discussed the relationship with drug induced sleep endoscopy (DISE) services and if there is an overlap with work. The specialty addressed and the RUC agreed that DISE *does* need to be performed to determine candidacy for hypoglossal nerve stimulator services (HGN). However, if the physician performs both services, these elective procedures are often separated by months, given the difficulty of scheduling surgeries at sleep medicine practices, and are not done closely together.

In addition, the RUC thoroughly discussed CPT code 64568 *Incision for implantation of cranial nerve (eg,* ***vagus nerve****) neurostimulator electrode array and pulse generator* (work RVU = 9.00, intra-service time of 90 minutes and total time of 275 minutes) which was reported with deleted Category III codes 0466T-0468T and agreed that the use of this vagus nerve code only represents part of the work involved in hypoglossal nerve stimulator services and does not address the distal inspiratory sensor, which is for a completely different site and incision as well as a completely different disease process and patient population. The physician work for hypoglossal nerve stimulator services is different than vagus nerve work. Identifying and placing a nerve stimulator on the trunk of the vagus nerve is different than identifying and placing a nerve stimulator on the distal and wispy branches of the hypoglossal nerve. The physician must find the specific branch that protrudes the tongue and implant it. Additionally, the physician is putting other cranial nerve branches at risk where they dissect to find the hypoglossal nerve. Hypoglossal nerve services are very different than the vagal nerve service in terms of patient population work intensity and risk. The RUC agreed with the specialty that there is evidence for increasing times and intensity for the additional work involved in the hypoglossal nerve stimulator family.

The RUC compared the survey code to the second key reference code 64911 *Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve* (work RVU = 14.00, intra-service time of 110 minutes and total time of 292 minutes) and noted that although both services involve similar total time, the survey code involves 30 minutes more of intra-service time and more total time, supporting a higher value of 16.00. Most survey respondents that selected the second key reference code 64911, also noted that the survey code was more intense/complex (71%), further warranting a work value of 16.00 for the survey code. Additionally, the RUC referenced code 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU= 16.84, intra-service time of 150 minutes and total time of 344 minutes) and noted that code 49655 has 10 more minutes of intra-service time and more total time, warranting the higher work value in comparison to the survey code. **The RUC recommends a work RVU of 16.00 for CPT code 64582.**

**64583** ***Revision or replacement of hypoglossal nerve neruostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing pulse generator***

The RUC reviewed the survey results from 67 otolaryngologists and determined that the survey median work RVU of 16.50 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 20 minutes of pre-service positioning time, 14 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 20 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

The RUC compared the survey code to code 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU = 16.84, intra-service time of 150 minutes and total time of 344 minutes) and noted that both services have identical intra-service times; however, reference code 49655 has more total time, warranting the higher work value than the recommended work value of 16.50 for the survey code. Additionally, the RUC compared the survey code to code 15736 *Muscle, myocutaneous, or fasciocutaneous flap; upper extremity* (work RVU= 17.04, intra-service time of 150 minutes and total time of 396 minutes) and noted that both codes have identical intra-service time, however reference code 15736 has a higher value because this service has more total time, supporting the recommended work value of 16.50 for the survey code. **The RUC recommends a work RVU of 16.50 for CPT code 64583.**

**64584** ***Removal of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array***
The RUC reviewed the survey results from 64 otolaryngologists and determined that the survey median work RVU of 14.00 accurately reflects the typical physician work necessary 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, 20 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

The RUC compared the survey code to code 58674 *Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency* (work RVU= 14.08, intra-service time of 120 minutes and total time of 266 minutes) and agreed that both codes involve identical intra-service time and similar total time, warranting the recommended work value of 14.00 compared to 14.08 for code 58674. Additionally, the RUC compared the survey code with MPC code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56, intra-service time of 120 minutes and total time of 279 minutes) and noted that both codes have identical intra-service times and very similar total times. However, MPC code 58674 is slightly more intense and has 0.56 more work RVUs than the survey code, further supporting the work value of 14.00 for the survey code. **The RUC recommends a work RVU of 14.00 for CPT code 64584.**

**Practice Expense**
The Practice Expense Subcommittee approved the standard 090-day global period direct practice expense inputs for CPT codes 64582, 64583 and 64584. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

**<u>Destruction of Intraosseous Basivertebral Nerve – Tab 14</u>**
**Wesley Ibazebo, MD (SIS), Morgan Lorio, MD (ISASS), Kano Mayer, MD (NASS), Carlo Milani, MD (AAPMR), Gregory Polston, MD (AAPM); David Reece, DO (AAPMR) and Karin Swartz, MD (NASS)**

**Facilitation Committee #2**

In October 2020, the CPT Editorial Panel approved the addition of two codes to report thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance for the first two vertebral bodies (lumbar or sacral) and for each additional vertebral body (lumbar or sacral).

**64628** ***Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral***
The RUC reviewed the survey results from 58 spine surgeons, physiatrists, and pain medicine physicians and determined that the survey median overestimated the work required to perform this service. After thorough discussion, the RUC recommends the survey 25th percentile work RVU of 8.25 to appropriately account for the physician work involved in this service. The RUC notes that the 25th percentile value results in a work intensity that closely aligns with the add-on code (0.085 and 0.081 IWPUT respectively). The RUC recommends: 56 minutes pre-service time (33 minutes evaluation, 10 minutes positioning, 13 minutes scrub/dress/wait time), 60 minutes intra-service time, and 20 minutes immediate post-service time, 0.5 99238 discharge visit and 1-99213 office visit.

The RUC noted that the survey 25th percentile value is appropriately bracketed by the two key reference service codes 22514 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar* (work RVU = 7.99 and 45 minutes intra-service time) and 22513 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic* (work RVU = 8.65 and 50 minutes intra-service time). The RUC concluded that CPT code 64628 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 8.25 for CPT code 64628.**

**64629** ***Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 58 spine surgeons, physiatrists, and pain medicine physicians and determined that the survey 25th percentile work RVU of 4.87, intra-service and total time of 60 minutes, appropriately accounts for the physician work required to perform this add-on service. The RUC noted that the 25th percentile value results in a work intensity that closely aligns with the base code (0.081 and 0.085 IWPUT respectively).

The RUC also noted that there are several ZZZ codes with 60 minutes of intra-service time and similar work RVUs. Specifically, CPT code 61799 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)* (work RVU = 4.81 and 60 minutes intra-service time) and CPT code 63103 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)* (work RVU = 4.82 and 60 minutes intra-service time) are spinal/cranial procedures with similar amount of physician work and identical intra-service times.
For further support, the RUC compared CPT code 64629 to the two key reference service codes 22515 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)* (work RVU = 4.00 and 30 minutes intra-service 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 and 45 minutes intra-service time) and agreed that these codes appropriately bracket the survey code. The RUC concluded that CPT code 64629 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 4.87 for CPT code 64629.**

**Practice Expense**
For CPT code 64628, the Practice Expense Subcommittee approved pre-service time for extensive use of clinical staff in the facility setting. The equipment inputs were modified to remove EQ168 *light, exam* and

add EF031 *table, power*. For CPT code 64629, no direct practice expense inputs are recommended as the practice expense for the add-on code is already included in the base code. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**New Technology**
CPT codes 64628 and 64629 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.

**Dilation of Aqueous Outflow Canal – Tab 15**
**David Glasser, MD (AAO), Emily Jones, MD (AAO/AGS) and Ankoor R. Shah, MD (AAO)**

**Facilitation Committee #2**

CPT codes 66174 and 66175 were identified through the New Technology/New Services List. In January 2020, the specialty societies submitted an action plan and the RUC recommended referral to the CPT Editorial Panel May 2020 meeting to possibly revise the descriptor and add exclusionary parentheticals for CPT 66174. In October 2020, the CPT Editorial Panel added a parenthetical to 66174 to restrict reporting this code in conjunction with CPT code 65820.

**66174** ***Transluminal dilation of aqueous outflow canal; without retention of device or stent***
The RUC reviewed the survey results from 72 ophthalmologists and assessed the relativity of CPT codes 66174 and 66175; the RUC determined that the relativity of the 25th percentile survey results should be maintained. The RUC determined that the increment between the 25th percentile work RVU value for CPT code 66174 (work RVU = 10.28) and the survey 25th percentile work RVU value for CPT code 66175 (work RVU = 12.00) would yield an increment between these two codes of 1.72. The specialty society agreed that this increment appropriately represents the value between these two codes (representative of the retention of device or stent). This comparison results in a work RVU recommendation of 8.53 for CPT code 66174 with 173 minutes total time. The RUC recommends 13 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 20 minutes of intra-service time, 6 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, and 4-99213 office visits.

For additional support, the RUC also reviewed CPT code 66174 by isolating the same-day work and comparing it to other existing 000-day global codes. The RUC selected two 000-day global codes: CPT code 15273 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* (work RVU = 3.50 and 20 minutes intra-service time) and CPT code 16035 *Escharotomy; initial incision* (work RVU = 3.74 and 20 minutes intra-service time). The RUC chose these values because they have intra-service times of 20 minutes (identical to the survey median intra-service time of 20 minutes). The RUC then added the total work RVU value of the 0.5-99238, 4-99213, and 1-99212 outpatient office visits (total work RVU = 5.00) to the selected bracket values. This methodology yields work RVU values of 8.50 for CPT code 15273 and 8.74 for CPT code 16035. This is a strong indication that the 8.53 work RVU recommendation for CPT code 66174 is appropriate when comparing to other services. **The RUC recommends a work RVU of 8.53 for CPT code 66174.**

**66175** ***Transluminal dilation of aqueous outflow canal; with retention of device or stent***
The RUC reviewed the survey results from 49 ophthalmologists for CPT code 66175 and determined that it was appropriate to recommend a direct work RVU crosswalk to CPT code 67110 *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (work RVU = 10.25, 30 minutes intra-service time, 196 minutes total time). The RUC recommends 13 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, 7 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, and 4-99213 office visits.

Additionally, the RUC compared the survey code to CPT code 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation* (work RVU = 10.25, 30 minutes of intra-service time, 175 minutes of total time) and noted that both codes have identical intra-service time and involve similar physician work, supporting the recommended work value of 10.25. **The RUC recommends a work RVU of 10.25 for CPT code 66175.**

**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.

**RUC Database Flag**
The RUC recommends to flag CPT code 66174 as "do not use to validate for physician work" since the RUC recommendation was not based on direct survey RVUs.

**Practice Expense**
For CPT codes 66174 and 66175, the Practice Expense Subcommittee approved the standard 090-day global period direct practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

**Cataract Removal with Drainage Device Insertion – Tab 16**
**David Glasser, MD (AAO); Emily Jones, MD (AAO/AGS), Parag Parekh, MD (ASCRS) and Ankoor R. Shah, MD (AAO)**

The RUC identified CPT code 0191T via the Category III codes with High Utilization screen (2018 estimated Medicare utilization over 1,000). In January 2020, the RUC recommended that the specialty societies develop a coding application for Category I status. In October 2020, the CPT Editorial Panel replaced two Category III codes with two new codes to report extracapsular cataract removal with insertion of intraocular lens prosthesis and one Category III code to report insertion of anterior segment aqueous drainage device without concomitant cataract removal.

***66989 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more***
The RUC reviewed the survey results from 113 ophthalmologists and cataract and refractive surgeons for CPT code 66989 and determined that the survey 25$^{th}$ percentile work RVU of 12.13 appropriately accounts for the work required to perform this service. The RUC recommends 26 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 28 minutes of intra-service time, 8 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, and 3-99213 office visit.

The RUC notes that the recommended intra-service time of 28 minutes of intra-service time for CPT code 66989 two minutes less the intra-service time of 30 minutes associated with CPT code 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the*

*amblyogenic developmental stage; without endoscopic cyclophotocoagulation*, while the intra-service time for CPT code 66991 is 5 minutes higher than the 20 minutes of intra-service time associated with code CPT 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation*. The RUC noted that this should not be the case, as the insertion of the intraocular lens prosthesis should take the same amount of time and be represented by the same relative work for both procedures. The RUC further noted that it is counterintuitive that 66989's intra-service time would be lower than 66982's intra-service time, as 66989 includes both complex cataract surgery and the insertion of the intraocular anterior segment aqueous drainage device. The specialty society explained that this is likely because the early adopters of this new technology service are highly skilled surgeons who perform these procedures quickly; as this procedure diffuses into the wider population of ophthalmologic surgeons over the next few years, the intra-service time will likely rise above the intra-service time associated with codes 66982 and 66984 and will come in line for both CPT 66989 and 66991.

The RUC compared CPT code 66989 to key reference services CPT code 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 13.20, total time 257 minutes) and CPT code 66179 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (work RVU = 14.00, total time 272 minutes) and determined that the difference between the survey 25$^{th}$ percentile work RVU value for 66989 and the work RVU value for 66982 appropriately represent the work associated with code 66989 and that this places 66989 in appropriate rank order with the two key reference services, both of which have higher total time and more intense physician work. **The RUC recommends a work RVU of 12.13 for CPT code 66989.**

**66991** ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more***

The RUC reviewed the survey results from 114 ophthalmologists and cataract and refractive surgeons for CPT code 66991 and assessed the relativity of CPT code 66991 and CPT code 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation*. The RUC agreed with the specialty society that the difference in work between CPT code 66989 and CPT code 66991 is whether the cataract procedure is complex (CPT code 66989) or routine (CPT code 66991). Therefore, the RUC determined that it would be appropriate to use the increment between the 25$^{th}$ percentile work RVU value for CPT code 66989 and the current RUC-reviewed work RVU value for CPT code 66982 to build a work RVU recommendation for CPT code 66991. The RUC determined that the increment between the 25$^{th}$ percentile work RVU value for CPT code 66989 (work RVU = 12.13) and the current RUC-reviewed work RVU value for CPT code 66982 (work RVU = 10.25) would yield an increment between those two codes of 1.88. This comparison results in a work RVU recommendation of 9.23 for CPT code 66991. The RUC recommends 25 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 25 minutes of intra-service time, 8 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, 3-99213 office visit. **The RUC recommends a work RVU of 9.23 for CPT code 66991.**

**Affirmation of RUC Recommendations**

The RUC reviewed the specialty society's request to affirm the recent valuations for CPT codes 66982, 66984, 66987 and 66988. The specialty society noted that these codes are in the same family as CPT codes 66989 and 66991 but did not need to be resurveyed for the January 2021 RUC meeting as they had just been reviewed at the January 2019 RUC meeting and that there have been no changes in the typical physician work, patient population, technology, and site of service associated with these procedures. The RUC noted that it would be necessary to re-survey this entire family of codes in two years once the new procedures described by CPT codes 66989 and 66991 have diffused into the wider ophthalmology

population. **The RUC recommends affirming the current work RVU of 10.25 for code 66982, 7.35 for code 66984, 13.15 for code 66987, and 10.25 for code 66988**.

**RUC Database Flag**
The RUC recommends flagging CPT code 66991 as "do not use to validate for physician work" since the RUC used an incremental work RVU building block methodology for valuation.

**Practice Expense**
For CPT codes 66989 and 66991, the Practice Expense Subcommittee approved the standard 090-day global period direct practice expense inputs. For CPT codes 66982, 66984, 66987, and 66988, the Practice Expense Subcommittee affirmed the current direct practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

**New Technology**
CPT codes 66989 and 66991 will be placed on the New Technology list and be re-reviewed by the RUC in two years (with CPT codes 66982, 66984, 66987, and 66988) to ensure correct valuation and utilization assumptions.

**Lacrimal Canaliculus Drug Eluting Implant Insertion – Tab 17**
**David Glasser, MD (AAO); Parag Parekh, MD (ASCRS) and Ankoor R. Shah, MD (AAO)**

In October 2020, the CPT Editorial Panel replaced CPT Category III code 0356T with a new CPT Category I code to report the insertion of a drug eluting implant into the lacrimal canaliculus.

**68841** ***Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each***
The RUC reviewed the survey results from 32 ophthalmologists for CPT code 68841 and agreed with the recommended direct work RVU crosswalk to CPT code 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU = 0.49, 3 minutes of intra-service time, and 11 minutes total time) as it has identical intra-service time and an almost identical IWPUT. The RUC recommends 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 1 minute of pre-service scrub/dress/wait time, 3 minutes of intra-service time, 2 minutes of immediate post-service time, and 12 minutes total time for code 68841. The RUC recommended work RVU of 0.49 is lower than the survey 25$^{th}$ percentile work RVU of 0.74. The RUC agreed with the recommended work value of 0.49 using code 65205 as a direct work RVU crosswalk because both codes involve identical intra-service time and similar physician work and with the specialty society's explanation that the 3 minutes of intra-service time and nature of this procedure warrant a direct work RVU crosswalk lower than the survey 25$^{th}$ percentile value.

CPT code 68841 describes placement of a drug delivery device through an intact punctum into the lacrimal canaliculus. CPT code 68841 is typically performed in a facility in conjunction with intraocular surgery, typically cataract surgery (CPT codes 66982 and 66984) to deliver an extended-release dose of corticosteroid to treat postoperative inflammation. The device is a drug formulation that dissolves over the course of about a month. However, it can be placed in the office setting during the post-operative period if there is an unexpected degree of inflammation or the patient has trouble administering eyedrops. It can also be used off-label for treatment of non-surgical ocular inflammatory disease. The specialty societies noted that they expect utilization to increase in the office setting once implants containing medications for treatment of glaucoma or other non-surgical diseases are approved and introduced.

CPT code 68841 will be performed as a standalone code as implants containing other medications are introduced or as off-label treatment of non-surgical inflammation. The specialty societies noted that is why this is designated as a 000-day global service. The RUC agreed, noting that it would be subject to the multiple procedure reduction when applicable. The specialty societies confirmed that the only currently approved drug is used in conjunction with an intraocular surgical procedure and may be placed during surgery or in the office during the 1-day post-operative visit. As additional drugs are approved, these will

likely be performed on the same day as an office visit. The specialty societies noted, and the RUC confirmed that the pre- and post-service times are much less than the established packages accounting for any overlap.

The RUC compared CPT code 68841 to the top two key reference services, CPT code 65222 *Removal of foreign body, external eye; corneal, with slit lamp* (work RVU = 0.84, 7 minutes of intra-service time, 15 minutes total time) and CPT code 65800 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (work RVU = 1.53, 5 minutes of intra-service time, and 28 minutes of total time) and noted that the time and intensity of work of these procedures indicates an appropriate rank order for the recommended work RVU and total time for CPT code 68841. by CPT code 65205. For additional support, the RUC referenced CPT code 68200 *Subconjunctival injection* (work RVU = 0.49 and 11 minutes total time). **The RUC recommends a work RVU of 0.49 for CPT code 68841**.

**New Technology**
This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Practice Expense**
The Practice Expense Subcommittee recognized that if CPT code 68841 is done independently, the clinical staff time would be extensive; however, 68841 is typically done with cataract surgery, so the specialty chose to use minimal clinical staff time. Also, any duplication in the service period due to placement typically on postoperative day one from cataract surgery has been eliminated. **The RUC recommends the direct practice expense units as submitted by the specialty societies.**

**<u>Transcutaneous Passive Implant-Temporal Bone – Tab 18</u>**
**R. Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)**

**Facilitation Committee #3**

In October 2020, the CPT Editorial 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.

**69714** ***Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 73 physicians and determined that a work RVU of 8.69 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 40 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and two office visit(s) (2x 99213).

The RUC recommends a direct work RVU crosswalk to CPT code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (work RVU= 8.69, intra-service time of 40 minutes and 197.5 minutes of total time) and noted that both codes have identical intra-service time, similar total time, and should be valued identically. The RUC agreed that due to the lack of 090-day global codes with 40 minutes of intra-service time, CPT code 52400 is an appropriate crosswalk for the work value, resulting in a work intensity that closely aligns with the revision/replacement of implant code 69717 (0.110 and 0.100 IWPUT respectively). The RUC agreed that code 52400 and the survey code have similar intra-service and total times and should be valued identically, below the survey's 25$^{th}$ percentile. **The RUC recommends an interim work RVU of 8.69 for CPT code 69714.**

**69716** ***Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 67 physicians and determined that a work RVU of 9.77 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 32 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60, immediate post service time of 15 minutes and total time of 207 minutes) and noted that both codes have identical intra-service time, identical post-service time and similar total time, and should be valued identically. The RUC agreed that an IWPUT of 0.100 is appropriate and that the recommended work value of 9.77 places the survey code well within the relativity of the family.

Additionally, the RUC agreed that the work value of 9.77 for code 69716 is appropriately bracketed by codes 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and total time of 201 minutes) and 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08 and total time of 211 minutes), further supporting a recommended work RVU of 9.77 for code 69716. **The RUC recommends an interim work RVU of 9.77 for CPT code 69716.**

**69717** ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 64 physicians and determined that a work RVU of 8.80 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and two office visit(s) (2x 99213).

The RUC recommends a direct work RVU crosswalk to CPT code 27829 *Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed* (work RVU= 8.80 and intra-service time of 45 minutes) to appropriately account for the physician work involved in this service. The RUC agreed that code 27829 is an appropriate crosswalk, the recommended work value of 8.80 for the survey code results in an IWPUT of 0.100. Additionally, the RUC agreed that the survey code should be valued identically to code 27829 because both services have identical intra-service time. **The RUC recommends an interim work RVU of 8.80 for CPT code 69717.**

**69719** ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 59 physicians and determined that the work RVU of 9.77 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, intra-service time of 60 minutes and total time of 207 minutes). The RUC agreed that the crosswalk to MPC code 50590 and recommended work value of 9.77 appropriately accounts for the physician work involved in this service because both codes have identical intra-service time, identical post-service time and similar total time. The RUC agreed that

an IWPUT of 0.099 is appropriate and that the recommended work value of 9.77 places the survey code well within the relativity of the family.

Additionally, the RUC agreed that the work value of 9.77 for code 69719 is appropriately bracketed by codes 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and total time of 201 minutes) and 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08 and total time of 211 minutes), further warranting a recommended work RVU of 9.77 for code 69719. **The RUC recommends an interim work RVU of 9.77 for CPT code 69719.**

**69726** ***Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor***

The RUC reviewed the survey results from 66 physicians and determined that the work RVU of 5.93 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 32 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and one office visit(s) (1x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 5.93, intra-service time of 30 minutes and total time of 142 minutes). The RUC agreed that the work value of 5.93 appropriately accounts for the physician work involved in this service. The RUC noted that the survey code and crosswalk code 53852 have identical intra-service time and similar total time. The RUC agreed that an IWPUT of 0.088 is appropriate and that the recommended work value of 5.93 places the survey code well within the relativity of the entire family. Additionally, the RUC agreed that the recommended work value of 5.93 is appropriate because this (removal) service has a lower intensity, in comparison to the implantation and revision/replacement services in the family. **The RUC recommends an interim work RVU of 5.93 for CPT code 69726.**

**69727** ***Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***

The RUC reviewed the survey results from 59 physicians and determined that the work RVU of 7.13 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and one office visit(s) (1x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to code 37718 *Ligation, division, and stripping, short saphenous vein* (work RVU = 7.13, intra-service time of 45 minutes and total time of 178 minutes). The RUC agreed that the crosswalk to code 37718 and recommended value of 7.13 appropriately accounts for the physician work involved in this service because the survey code and crosswalk code have identical intra-service time and similar total time. The RUC agreed that an IWPUT of 0.085 is appropriate and is like (removal) code 69726 (IWPUT = 0.088) in the family, therefore the recommended work value of 7.13 places the survey code well within the relativity of the entire family. Additionally, the RUC agreed that the recommended work value of 7.13 is appropriate because this (removal) service has a lower intensity, in comparison to the implantation and revision/replacement services in the family.

The RUC agreed that the recommended work value of 7.13 is appropriately bracketed by codes 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, intra-service

time of 45 minutes and total time of 161 minutes) and 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, intra-service time of 45 minutes and total time of 185 minutes). **The RUC recommends an interim work RVU of 7.13 for CPT code 69727.**

**Resurvey for April 2021 RUC Meeting**
In January 2021, the RUC reviewed these services and determined that they need to be interim and resurveyed for the April 2021 RUC meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically relative values on the lower end of the spectrum. Additionally, there was concern from the specialty that survey respondents may not have fully understood the new removal codes based on the anomalous intra-service time response for code 69726 which was less than all other codes in the family.

**Practice Expense**
The Practice Expense Subcommittee replaced one SA053 *pack, post-op incision care (suture and staple)* with one SA054 *pack, post-op incision care (suture)*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**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.

**Trabecular Bone Score – Tab 19**
**Lauren Golding, MD (ACR), Andrew Moriarity, MD (ACR) and Kurt Schoppe, MD (ACR)**

In October 2020, the CPT Editorial Panel created four new CPT codes to describe trabecular bone score (TBS) analysis. CPT codes 77090 and 77091 involve only technical work. The specialty noted that TBS can be performed synchronously with a dual-energy X-ray absorptiometry (DXA) or if a patient had a prior DXA within a clinically relevant amount of time. In addition, TBS analysis for bone micro architecture can also be performed on a previous appropriately acquired CT scanogram or other appropriate imaging study, avoiding the need for the patient to undergo additional imaging. TBS can also be a stand-alone service with imaging acquired independently of a DXA scan or separate imaging scan; that is the reason the service was created as an XXX base code instead of an add-on service. TBS is an independent variable for assessing a patient's osteoporatic risk and fracture risk.

***77089 Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk***
The RUC reviewed the survey results from 33 diagnostic radiologists and recommends the survey 25th percentile work RVU of 0.20 for CPT code 77089. The RUC recommends 2 minutes of pre-service time, 5 minutes of intra-service time and 2 minutes of post-service time. The specialty noted that the physician work performed by the radiologist is identical for services 77089 and 77092 and that the sole distinction between these two services is related to practice expense.

The specialty noted that for most of the physician time, the interpreting physician is assessing the images provided, assessing the areas of the target analysis and then reviewing that data in comparison to other clinical information. Both DXA and TBS involve an extensive clinical questionnaire because the data cannot be assessed in the absence of appropriate clinical history, medication review and the patient's prior pertinent studies. Both for DXA and TBS, if the patient has prior fractures in the areas of analysis that would be a feedback in which the interpreting physician would need to associate or analyze a different area within that bone, because it would be possible to get spurious or incorrect data.

To justify a value of 0.20, the RUC compared the survey code to 2nd key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU= 0.20, intra-service time of 5 minutes, total time of 9

minutes) and noted that both services typically involve an identical amount of time and physician work for the radiologist performing the service. The RUC also compared the survey code to MPC code 74019 *Radiologic examination, abdomen; 2 views* (work RVU= 0.23, intra-service time of 4 minutes, total time of 6 minutes) and noted that the MPC code, with three minutes less of total time, is a slightly more intense service to perform. **The RUC recommends a work RVU of 0.20 for CPT code 77089.**

**77092** ***Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified health care professional***
The RUC reviewed the survey results from 33 diagnostic radiologists and recommends the survey median work RVU of 0.20 for CPT code 77092. The RUC recommends 2 minutes of pre-service time, 5 minutes of intra-service time and 2 minutes of post-service time. The specialty noted that the physician work performed by the radiologist is identical for services 77089 and 77092 and that the sole distinction between these two services is related to practice expense.

The specialty noted that, for this service, the interpreting physician is assessing the images provided and then assessing the areas of the target analysis and then reviewing that data in comparison to other clinical information. Both DXA and TBS involve an extensive clinical questionnaire because the data cannot be assessed in the absence of appropriate clinical history, medication review and the patient's prior pertinent studies. For both DXA and TBS, if the patient has prior fractures in the areas of analysis that would be a feedback in which the interpreting physician would have to associate or analyze a different area within that bone, because it would be possible to get spurious or incorrect data.

To justify a value of 0.20, the RUC compared the survey code to 2nd key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU= 0.20, intra-service time of 5 minutes, total time of 9 minutes) and noted that both services typically involve an identical amount of time and physician work for the radiologist performing the service. The RUC also compared the survey code to MPC code 74019 *Radiologic examination, abdomen; 2 views* (work RVU= 0.23, intra-service time of 4 minutes, total time of 6 minutes) and noted that the MPC code, with three minutes less of total time, is a slightly more intense service to perform. **The RUC recommends a work RVU of 0.20 for CPT code 77092.**

**Practice Expense**
The Practice Expense Subcommittee reviewed the proposed direct practice expense inputs and agreed they were appropriate, as proposed by the specialty. The specialty explained that CPT code 77089 describes the complete TBS service when the TBS software is installed on the imaging equipment, including physician review and interpretation of the TBS report. CPT code 77090 is used to report when data is extracted from the imaging equipment and sent elsewhere for TBS analysis. CPT code 77091 is used when only TBS is performed, and CPT code 77092 captures the physician review and interpretation of TBS. CPT codes 77090 and 77091 are technical work only. The Subcommittee agreed that it would be warranted to include a per encounter software licensing fee for the TBS software for CPT codes 77089 and 77091. The software is currently sold "per click" or per scan. As this is a per-patient, single-use item, it is appropriately included as a supply item and not an equipment item, which is typically accounted for by minutes used. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

**New Technology/New Service**
The RUC recommends that CPT codes 77089-77092 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**<u>Pathology Clinical Consult – Tab 20</u>**
**James Fink, MD (CAP), Andrew Hoofnagle, MD, PhD (CAP), Michael Laposata, MD (CAP), Ronald McLawhon, MD, PhD (CAP), Roger McLendon, MD (CAP), Swati Mehrotra, MD (CAP) and Oksana Volod, MD (CAP)**

The Relativity Assessment Workgroup identified CPT code 80500 via the CMS/Other source codes with the Medicare utilization over 20,000 screen. In October 2019, the RUC referred this issue to the CPT Editorial Panel to define this service more specifically as the current descriptor is vague. In October 2020, the CPT Editorial Panel replaced two codes with four new codes to report pathology clinical consultation and creation of guidelines to select and document the appropriate level of service.

***Compelling Evidence***
These services are exactly work neutral based on the utilization assumptions for the to be deleted codes, 80500 and 80502, to the new services. However, to account for any fluctuations and recognizing change in these services since CMS valued them, the specialty societies provided compelling evidence. The specialty society indicated that incorrect assumptions were made in the previous valuation of this service, physician work has changed due to technology advances and the patient population has changed. These services were valued via an unknown CMS crosswalk method over 30 years ago. This represents a flawed valuation assumption methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC. In the last 30 years, there has been an explosive growth in the number and complexity of laboratory tests, development of new drugs, and increased numbers of patients living with chronic diseases. Consequently, the role of the consulting pathologist to investigate and explain these issues has similarly grown and become more complex. Patients are frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre-transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for ordering physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of an ordering physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

The RUC determined that compelling evidence has been met that this service was previously valued based on a flawed methodology, the physician work has changed due to technology advances and the patient population has changed.

A CMS representative questioned if the pathologist work in these services is more like a standard consultation service based on the description of work provided. The description of work has elements similar to the non-pathology consultation services, such as pre-service work for review of medical records and post-service work to confer findings with the clinical team. The Chair of the Research Subcommittee indicated that this question did come to the Research Subcommittee and the specialties indicated the difference was that because these services are not a direct patient to pathologist face-to-face encounter, but rather a provider to the pathologist encounter regarding a patient, the activities as they described them occurred in one continuous sitting. In other words, a provider calls the pathologists and he or she at that moment is looking through the previous studies, the history, providing the recommendation and then it all was one single intra-service encounter.

A CMS representative also questioned, that in the medical decision making (MDM) grid, to bump up to another level is the assessment requiring an independent historian. In the office visit MDM table, the independent historian could be a caregiver. Since none of that is described in the description of physician

work, what is the relevance here for medical decision making for the pathologist? The specialty society indicated that the definition of independent witness here could be anyone, including a nurse. When a pathologist calls to get independent information, they may call and talk to a nurse and that would qualify as an independent historian.

**80503** ***Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.***
The RUC reviewed the survey results from 53 pathologists and determined that the survey 25th percentile work RVU of 0.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of services and comparable to other XXX codes with this amount of physician time.

The RUC compared CPT code 80503 to the top two key reference services, CPT code 85060 *Blood smear, peripheral, interpretation by physician with written report* (work RVU = 0.45 and 12 minutes intra-service time) and 88305 *Level IV Surgical Pathology* (work RVU = 0.75 and 25 minutes intra-service time), which appropriately bracket the recommended physician work and time for this service.

For additional support, the RUC referenced MPC code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50 and 15 minutes total time) and code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50 and 15 minutes total time), which require the exact same physician work and time. **The RUC recommends a work RVU of 0.50 for CPT code 80503.**

**80504** ***Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.***
The RUC reviewed the survey results from 54 pathologists and determined that the survey 25th percentile work RVU of 0.91 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of services and comparable to other XXX codes with this amount of physician time.

The RUC compared CPT code 80504 to the top two key reference services, CPT 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU = 1.63 and 50 minutes intra-service time) and 85390 *Fibrinolysins or coagulopathy screen, interpretation and report* (work RVU = 0.75 and 20 minutes intra-service time), which appropriately bracket the recommended physician work and time for this service.

For additional support, the RUC referenced MPC codes 92012 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient* (work RVU = 0.92 and 25 minutes total time) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93 and 20 minutes total time), which require similar physician work and time. **The RUC recommends a work RVU of 0.91 for CPT code 80504.**

**80505** ***Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.***
The RUC reviewed the survey results from 54 pathologists and determined that the survey 25th percentile work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC

recommends 54 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of service and comparable to other XXX codes with this amount of physician time.

The RUC compared CPT code 80505 to the top two key reference services, 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (work RVU = 2.85 and 90 minutes intra-service time) and 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU = 1.63 and 50 minutes intra-service time), which appropriately bracket the recommended physician work and time for this service.

For additional support, the RUC referenced MPC codes 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.82 and 40 minutes total time) and 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 60 minutes total time) and 36456 *Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn*, (work RVU = 2.00 and 60 minutes total time), all which require similar physician work and time. **The RUC recommends a work RVU of 1.80 for CPT code 80505.**

**80506** ***Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 pathologists and determined that the survey 25$^{th}$ percentile work RVU of 0.80 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of service and comparable to other XXX codes with this amount of physician time.

The RUC compared CPT code 80506 to the top two key reference services, 88189 *Flow cytometry, interpretation; 16 or more markers* (work RVU = 1.70 and 36 minutes intra-service time) and 88356 *Morphometric analysis; nerve* (work RVU = 2.80 and 90 minutes intra-service time, both which require more physician work, time and intensity that the surveyed code.

For additional support, the RUC referenced MPC ZZZ codes 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 30 minutes total time), 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes total time) and 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 16 minutes total time). **The RUC recommends a work RVU of 0.80 for CPT code 80506.**

**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**
The Practice Expense Subcommittee agreed that there is compelling evidence that the practice expense has changed due to this service being previously valued based on a flawed methodology, technology advances and change in the patient population (as specified in the compelling evidence that physician work has changed). The PE Subcommittee removed the equipment item ED021 *computer, desktop, w-monitor*, as it is not specifically dedicated to the procedure. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**Colon Capsule Endoscopy – Tab 21**
**R. Bruce Cameron, MD (ACG), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE) and Shivan Mehta, MD (AGA)**

In October 2020, the CPT Editorial Panel replaced one Category III code with a new Category I code to report gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report. Codes 91110 and 91111 were added as part of the family to be surveyed for the January 2021 RUC meeting.

**91110** ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report***
The RUC reviewed the survey results from 104 gastroenterologists and agreed that the survey 25th percentile work RVU of 2.24 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 5 minutes of pre-service time, 40 minutes of intra-service time, and 10 minutes of immediate post-service time. During the intra-service period, which is intraluminal imaging of the esophagus through ileum, 70,000 images are captured. Specifically, the physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (e.g., esophagogastric junction, duodenum, ileocecal valve, hepatic flexure, splenic flexure), permitting identification of potentially positive findings and determination of gastric and small bowel emptying times. Once the landmarks are determined, all images are viewed. When the physician identifies an abnormality, a thumbnail is created. Key findings or abnormalities are noted, and localization is determined by passage of time or by capsule localization software. The RUC agreed the intensity relativity is appropriate and that the recommended work value of 2.24 places the survey code well within the relativity of the family.

The RUC compared the survey code to the top key reference code 74262 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed* (work RVU= 2.50, intra-service time of 45 minutes and total time of 57 minutes) and noted that both codes have similar intra-service time and similar total time and should be valued similarly. Code 74262 has five additional minutes of intra-service time and two additional minutes of total time, which accounts for the higher work value. In addition, most of the survey respondents that selected the top key reference code had indicated either that the survey code has similar or more intensity (100% of those survey respondents that selected the top key reference code also rated the survey code identical to much more intense/complex), justifying similar IWPUTs and WPUTs for both services. Additionally, the RUC compared the survey code to code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material;* (work RVU= 2.35, intra-service time of 40 minutes, and total time of 60 minutes) and noted that both codes require identical intra-service time and very similar total time however, code 75557 has 5 more minutes of total time, supporting the work value for the survey code at the survey 25th percentile of 2.24. **The RUC recommends a work RVU of 2.24 for CPT code 91110.**

**91111** ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report***
The RUC reviewed the survey results from 56 gastroenterologists and agreed that the current value of 1.00, which is below the survey 25th percentile, accurately reflects the typical physician work necessary to perform this service. The RUC recommends 5 minutes of pre-service time, 15 minutes of intra-service time, and 5 minutes of immediate post-service time. During the intra-service period, which is intraluminal imaging of the esophagus, 15,000 images are captured. Specifically, the physician reviews the images and scans the entire study and annotated keys anatomic landmarks. Once the landmarks have been determined, all images are viewed by the physician. When an abnormality is identified, a thumbnail is created. The physician notes and records key findings or abnormalities on a localization drawing that may also be used to guide subsequent management of the patient. Localization is determined by passage of time or by capsule

localization software. The RUC agreed that the intensity relativity is appropriate and that the recommended current work value of 1.00 places the survey code well within the relativity of the family.

The RUC compared the survey code to code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, pre-service time of 5 minutes, intra-service time of 15 minutes and post-service time of 4 minutes) and agreed that both codes have identical pre-service time, identical intra-service time, similar total time, and should be valued similarly. Code 70470 however, has one minute less of total time, supporting the recommended current value of 1.00 for the survey code. Additionally, the RUC compared the survey code to code 76391 *Magnetic resonance (eg, vibration) elastography* (work RVU= 1.10, pre-service time of 5 minutes, intra-service time of 15 minutes, and post-service time of 5 minutes) and MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep (*work RVU = 1.08, pre-service time of 5 minutes, intra-service time of 15 minutes, and post-service time of 6 minutes). **The RUC recommends a work RVU of 1.00 for CPT code 91111.**

**91113** ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report***
The RUC reviewed the survey results from 58 gastroenterologists and agreed that the survey 25th percentile work RVU of 2.41 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 5 minutes of pre-service time, 45 minutes of intra-service time, and 10 minutes of immediate post-service time. During the intra-service period, which is intraluminal imaging of the colon, 100,000 images are captured, reviewed and annotated. Specifically, the physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (e.g., esophagogastric junction, first gastric image, first duodenal image, ileocecal valve, first cecal image, hepatic flexure, splenic flexure, and last rectal image), permitting identification of potentially positive findings and determination of gastric, small bowel and colonic transit times. Once the landmarks are identified, all images are then viewed with the two different (front and back) capsule cameras. This is in effect reviewing two capsule studies, one from the forward view camera and one from the trailing view camera. When the physician identifies an abnormality, it is measured, and a thumbnail is created. Images or abnormalities that are noted on the two different viewing cameras must be carefully analyzed and reconciled to determine if they represent two distinct pathologies or the same pathology from two different vantage points. This is critically important to avoid false positive findings. Localization is then determined by passage of time or by capsule localization software. The RUC agreed that intensity relativity is appropriate and that the recommended work value of 2.41 places the survey code well within the relativity of the family.

The RUC compared the survey code to the top key reference code 74262 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed* (work RVU = 2.50, pre-service time of 5 minutes, intra-service time of 45 minutes, and post-service time of 7 minutes) and noted that both codes have identical pre-service time, identical intra-service time, similar total time, and should be valued similarly. Most survey respondents (61%) who selected code 74262, rated the survey code more intense/complex, further supporting the survey 25th percentile work value of 2.41. Additionally, the RUC compared the survey code to MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 2.40, intra-service time of 39 minutes, and total time of 57 minutes) and noted that the survey code requires slightly more physician work and intra-service time and is therefore valued appropriately. **The RUC recommends a work RVU of 2.41 for CPT code 91113.**

**New Technology/New Service**
The RUC recommends that CPT code 91113 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Practice Expense**

The Practice Expense Subcommittee accepted the two new supplies 1 *PillCam® COLON 2 capsule* and *sensor sleeves* for code 91113 and removed SK087 *water, distilled*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**Cardiac Ablation – Tab 22**
**Chris Liu, MD (HRS), Mark Schoenfeld, MD (HRS), David Slotwiner, MD (HRS), Edward Tuohy, MD (ACC), Thad Waites, MD (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.

**Rationale for Interim Recommendation**
The specialties submitted a letter to the CPT Editorial Panel on December 14, 2020 requesting for the coding changes for these services to be rescinded for CPT 2022; however, as this request will not be considered until after the January 2021 RUC meeting and January 2021 is the last RUC meeting of the CPT 2022 cycle, the specialties have made a separate request to the RUC for the RUC's recommendations for these services to be interim.

During the presentation to the RUC, the specialties noted that despite the inclusion of comprehensive changes to the CPT introductory language, their multispecialty advisory committee believed that many of the survey respondents did not realize that the codes had been revised. The specialties noted that they inferred that this occurred because respondents may not have read the updated code descriptors thoroughly and that a contributing factor may be that the CPT code numbers did not change. Given respondents' familiarity with the existing code numbers, and their current ability to separately report the newly bundled services, the specialties asserted that there is a strong possibility that many of the survey participants based their assumptions on the current reporting rules where several services are separately reportable. The RUC discussed whether the survey respondents were confused by the change in reporting rules for this family of services. Although several RUC members did note that the survey physician times for 93654 seemed to be potentially incongruent with 93653 and 93656, the RUC noted that it was unclear whether most of the survey respondents understood the coding changes. **The RUC recommends for these services to be valued as interim and that these services will 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 74 cardiac electrophysiologists and recommends the survey median work RVU of 18.49 for CPT code 93653. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 125

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.

To justify a value of 18.49, 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 the survey code involves 5 more minutes of intra-service time and that 89 percent of the survey respondents that selected the top key reference code had also indicated that the survey code is a more intense and complex procedure to perform. The RUC also compared the survey code to CPT code 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, intra-service of 135 minutes, total time of 223 minutes) and noted that the reference code involves 10 more minutes of intra-service time and total time and is a somewhat more intense service to perform, supporting a somewhat lower value for the survey code. The specialty noted and the RUC concurred that there are very few major surgical procedures that are 000-day or XXX to use as reference codes to compare to the survey code. **The RUC recommends an interim work RVU of 18.49 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 survey results from 73 cardiac electrophysiologists and agreed that the survey respondents, with a 25th percentile work value of 20.00, narrowly overvalued the physician work involved in performing this service. The RUC recommends maintaining the current value of 19.75 for CPT code 93654. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 20 minutes of pre-service scrub/dress/wait time, 240 minutes of intra-service time and 33 minutes of immediate post-service time.

To justify a work value of 19.75, the RUC compared the survey code to top key reference 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 40 more minutes of intra-service time and 66 more minutes of total time. The specialty noted that the survey times for this service relative to the other services in this tab, which were all surveyed on the same survey instrument, made them think the survey respondents may not have considered the bundling of 3D mapping for the services in this tab. CPT code 93654 previously included 3D mapping, whereas the other services in the tab are newly having that work bundled in. The specialty noted and the RUC concurred that there are very few major surgical procedures that are 000-day or XXX to use as reference codes to compare to this survey code. **The RUC recommends an interim work RVU of 19.75 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 survey results from 74 cardiac electrophysiologists and agreed that the survey respondents, with a 25th percentile work value of 8.00, overvalued the physician work involved in

performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU= 6.50, intra-service and total time of 60 minutes) would be appropriate, as both add-on services typically involve an identical amount of time and physician work intensity to perform. The RUC recommends 60 minutes of intra-service time for CPT code 93655

CPT codes 93653, 93654 and 93656 are the three base codes that add-on code 93655 will be reported with. All three of these base codes will have the work of 3D mapping bundled in. The RUC noted that 93655 is most often an add-on code reported with 93656 (83% of the time per 2018 Medicare 5% file).

To further support a work value of 6.50, the RUC 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, whereas the reference service is a slightly more intense procedure to perform. **The RUC recommends an interim work RVU of 6.50 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 73 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 20.00 for CPT code 93656. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 20 minutes of pre-service scrub/dress/wait time, 210 minutes of intra-service time and 33 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.

To justify a value of 20.00, the RUC compared the survey code to 2nd key reference 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 30 more minutes of intra-service time and 36 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, total time of 355) and noted that although the survey code involves 10 more minutes of intra-service time, the reference code includes 49 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 are 000-day or XXX to use as reference codes to compare to this survey code. **The RUC recommends an interim work RVU of 20.00 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 survey results from 74 cardiac electrophysiologists and agreed that the survey respondents, with a 25th percentile work value of 8.00, overvalued the physician work involved in

performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU= 6.50, intra-service and total time of 60 minutes) would be appropriate, as both add-on services typically involve an identical amount of time and physician work intensity to perform. The RUC recommends 60 minutes of intra-service time.

To further support a work value of 6.50, the RUC 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, whereas the reference service is a slightly more intense procedure to perform. **The RUC recommends an interim work RVU of 6.50 for CPT code 93657.**

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

**Bundled Add-on Services for Next LOI**
A RUC member noted that even though the work of add-on services 93613, 93621 and 93662 are being bundled into CPT codes 93653 and/or 93656, these add-on codes are being retained as they may also be reported with other CPT codes. However, these services are each typically reported with either 93653 or 93656 in the 2018 Medicare billed together data. These services will be added to the LOI along with 93653-93657 for the April 2020 RUC meeting.

**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.

**Outpatient Pulmonary Rehabilitation Services - Tab 23**
**Amy Ahasic, MD (CHEST), Brian Carlin MD (ATS), Robert DeMarco, MD (CHEST), Chris Garvey, FNP, MSN (ATS), Katina Nicholacakis, MD (ATS) and Alan Plummer, MD (ATS)**

In September 2020, the CPT Editorial Panel created two new codes to report physician or other qualified healthcare professional services for outpatient pulmonary rehabilitation, with and without continuous oximetry monitoring (per session). The specialty societies indicated they expect the two new codes to replace G0424 *Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day.*

**Compelling Evidence**
CMS HCPCS code G0424 *Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day* (work RVU = 0.28) was created in 2010, prior to publication of the detailed joint medical specialty Outpatient Pulmonary Rehabilitation (OPR) clinical guidelines in 2013. There is now a new definition of pulmonary rehabilitation, which states that pulmonary rehabilitation is a comprehensive intervention based on a thorough patient assessment, followed by patient tailored therapies that include but are not limited to exercise training, education and behavioral change to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health enhancing behaviors. Pulmonary Rehabilitation is now recognized as a core component of management of chronic obstructive pulmonary disease (COPD), and particularly focusing on health behavior change for this chronically ill population. However, patients with other advanced lung diseases can also participate in pulmonary rehabilitation.

In 2010, a survey was not conducted on the dominant performing specialty, Pulmonary Medicine. Therefore, the specialty societies presented, and the RUC agreed that compelling evidence is met due to incorrect assumptions/flawed methodology of the CMS/Other valuation, the code was not surveyed by pulmonary medicine physicians and the joint society clinical guidelines outline details were not captured nor valued in G0424. Additionally, there is documentation in peer-reviewed medical literature that there has been a change in the physician work due to both changes in technique, the updated guidelines and change in patient population to predominantly COPD patients.

**94625** ***Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)***
The RUC reviewed the survey results of 39 pulmonologists and determined that the survey 25th percentile work RVU of 0.55 appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 9 minutes intra-service time and 10 minutes immediate post-service time. The RUC agreed with the specialty societies to decrease the intra-service time from the survey respondents' time of 15 minutes to 9 minutes.
The typical patient for 94625 is significantly more stable and less sick than the typical patient of 94626. The new CPT codes are different than G0424 as they are used per session and only once per day. The typical pulmonary rehabilitation program for a patient is a total of 36 sessions. CMS limits that to 72 sessions lifetime. These occur several days a week, typically two or three days per week spanning a total of two or three months. The patients typically have sessions which last 90 minutes or more with exercise rotations each being 10 to 20 minutes each with time in between for an assessment of dyspnea as well as obtaining vital signs. The patients are in the office setting and are typically not in a group setting. The physician or qualified health provider is available and typically interacts with either the respiratory therapist (RT) or both the RT and the patient during and post- session. These patients typically need modifications to the plan to achieve success. The physician is not typically scheduled for other activities, such as Evaluation and Management (E/M) visits, while filling the role of the supervising physician. They may be performing administrative tasks or other non-face-to-face tasks but must be immediately available throughout the session.

In summary, the widely varying times that a physician participates in each session challenged the survey participants as it required them to consider the total times that are typical for all the sessions and then divide by the number of sessions to come up with a typical average session. Therefore, the specialty societies recommended revised times of 2 minutes pre-service evaluation time, 9 minutes intra-service time and 10 minutes immediate post-service time. The 9 minutes of intra-service time is the survey 25th percentile since this is clearly a more stable population than those receiving 94626 and would involve less physician involvement during their exercise period.

The RUC compared CPT code 94625 to the top key reference services, code 99497 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate* (work RVU = 1.50 and 30 minutes intra-service time) and 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28 and 20 minutes of intra-service time). The RUC noted that the surveyed code requires much less physician time and work to perform, thus is appropriately valued lower.

For additional support, the RUC referenced MPC code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50 and 15 minutes total time) and code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50 and 15 minutes total time), which require similar physician work and time. **The RUC recommends a work RVU of 0.55 for CPT code 94625.**

**94626** ***Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)***
The RUC reviewed the survey results of 39 pulmonologists and determined that the survey 25th percentile work RVU of 0.69 appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 14 minutes intra-service time and 10 minutes immediate post-service time.

The specialty society indicated that the patient population for 94626 will require oxygen at the onset. This is a patient population with advanced respiratory failure, who are already on oxygen, who will desaturate with exercise probably needing anywhere from four to six liters of oxygen per minute. These patients may have significant supraventricular arrhythmias, a-fibrillation with rapid ventricular response, non-sustained ventricular tachycardia or syncope in addition to their COPD exacerbations. Those are all significantly more likely and more common in the 94626 population, and much less common in the 94625 population, which is why the intra-service time is higher for 94626.

The RUC compared CPT code 94626 to the top key reference service, code 94621 *Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings* (work RVU = 1.42, 30 minutes intra-service time and 50 minutes total time), noting that the surveyed code requires less physician work and time to perform. The RUC compared the surveyed code to the second top key reference code 99231 *Subsequent hospital care, per day…Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit* (work RVU = 0.76, 10 minutes of intra-service time and 20 minutes total time), noting both require similar physician work and time to perform.

For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70, 15 minutes intra-service time and 20 minutes total time) and code 94617 *Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)* (work RVU = 0.70, 10 minutes intra-service time and 26 minutes total time), which require almost identical physician work and time. **The RUC recommends a work RVU of 0.69 for CPT code 94626.**

CMS questioned and the specialty societies confirmed that any expected adverse reactions are included in the valuation for these codes since an E/M service would not be reported on the same date of service. Therefore, there will not be an issue if there are any edits to the E/M codes in the near future.

**G Code Deletion**
The RUC requests that CMS delete G0424, as these services could be reported by 94625 and 94626.

**Practice Expense**
The Practice Expense Subcommittee accepted the compelling evidence that the following have changed for these services: the dominant provider, the clinical guidelines, the technology/technique and patient population as outlined in the compelling evidence for work valuation above. The Practice Expense Subcommittee made a modification to the type of paper to SK057 *paper, laser printing (each sheet)*. The Subcommittee noted the specialties' use of L042B *Respiratory Therapist* for its clinical staff inputs. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**New Technology/New Services**
CPT codes 94625 and 94626 will 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.

**Remote Therapeutic Monitoring – Tab 24**

**Steven Krug, MD, FAAP (AAP), Carlo Milani, MD (AAPMR), Richard Rausch, DPT, MBA (APTA), David Reece, DO (AAPMR) and Korinne Van Keuren, DNP, MS, RN (ANA)**

In October 2020, the CPT Editorial Panel created five new CPT codes to report remote therapeutic monitoring services. Remote physiologic monitoring treatment management services are provided when a physician or qualified health care professional (QHP) and/or clinical staff use the results of remote physiological monitoring to manage a patient under a specific treatment plan.

**98980** ***Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes***
The RUC reviewed the survey results from 50 physicians and qualified health care professionals (QHPs) for CPT code 98980 and determined that the survey 25th percentile work RVU of 0.62 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes of intra-service time. The RUC noted that a physician/QHP would not be permitted to report this code if that physician/QHP spent less than 20 minutes performing these services across a given calendar month and that this work would include 2-3 minutes of data review every few days and an interactive communication with the patient once per month. The RUC also discussed the vignette and the fact that the typical patient is an 8-year-old with asthma. The specialty societies noted that only 46 percent of survey respondents found the vignette to be typical. The respondents and the specialty noted the typical patient to be older and have complex medical conditions and co-morbidities, particularly following surgical procedures after which these treatment/monitoring devices would be provided.

The RUC compared CPT code 98980 to the top key reference service CPT code 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* (work RVU = 0.61, 20 minutes total time) and determined that both services require nearly identical physician work, time and intensity, which supports the RUC recommended work RVU valuation of 98980. The RUC also compared 98980 to CPT code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50, 15 minutes total time) and noted that 98980 requires 5 minutes of additional time because there is considerably more data review and collection associated with 98980 across a period of 30 days, compared with a period of 7 days for 99422. **The RUC recommends a work RVU of 0.62 for CPT code 98980.**

**98981** ***Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 physicians and qualified health care professionals (QHPs) for CPT code 98981 and determined that the survey 25th percentile work RVU of 0.61 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes of intra-service time. The RUC compared CPT code 98981 to the top key reference service CPT code 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.61, total time 20 minutes) and determined that both services require the same physician work, time and intensity.

The RUC discussed the valuation of key reference services 99457 (work RVU = 0.61) and 99458 (work RVU =0.61) and noted that these key reference services have identical work RVU values. This supports the same relativity between CPT codes 98980 and 98981 being nearly identical. The specialty societies also noted that a typical patient for 98981 is inherently complex and needs additional evaluation and

information gathering and that the work associated with this would essentially be identical to that of the base code. **The RUC recommends a work RVU of 0.61 for CPT code 98981.**

**New Technology/New Services**
CPT codes 98975, 98976, 98977, 98980 and 98981 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Practice Expense**
The Practice Expense Subcommittee adjusted the CA021 clinical staff time to reflect the typical musculoskeletal patient for CPT code 98975; discussed the leasing/rental fee for the new supply item associated with CPT code 98976; and noted the need for the specialty societies to obtain a paid invoice for the new equipment item for CPT code 98977. **The RUC recommends the direct practice expense inputs as modified** by the Practice Expense Subcommittee. The RUC notes that the specialty societies were unable to obtain a paid invoice for the new equipment item by the date of submission and **recommends that CMS work directly with the specialty societies and others to determine the acquisition costs for the new equipment item *Remote musculoskeletal therapy system.*** CMS has experience with a similar situation where the Agency worked directly with a cardiac device manufacturer to attain the manufacturing costs and other proprietary information for a separate cardiac device.

**Principal Care Management and Chronic Care Management - Tab 25**
**Megan Adamson, MD (AAFP), Audrey Chun, MD (AGS), Charles Crecelius, MD, PhD (AMDA), Tanvir Hussain, MD, MBA (ACP), Steven Krug, MD (AAP), Joshua Liao, MD, MSc (ACP), Phillip Rodgers, MD (AAHPM), Joseph Schlecht, DO (AOA), Fredrica Smith, MD (ACRh), Marianna Spanaki, MD, PhD (AAN) and Korrine Van Keuren, DNP, MS, RN (ANA)**

In September 2019, the CPT Editorial Panel created add-on code 99439 and in January 2020, the RUC made an interim recommendation. At that time, the RUC noted that the specialty societies were developing a CPT coding change application (CCA) to establish principal care management codes and CPT codes 99490, 99439, 99491, 99487 and 99489 would be resurveyed as part of this family of services. Additionally, in October 2020, the RUC flagged CPT codes 99487-99490 via the New Technology/New Services screen. The Relativity Assessment Workgroup reviewed the most recent years of available Medicare claims data (2017, 2018 and preliminary 2019 data) and the RUC recommended these services be surveyed for January 2021, along with the principal care management codes considered at the October 2020 CPT meeting. In October 2020, the CPT Editorial Panel created a new subsection within the Evaluation and Management (E/M) section to identify Principal Care Management (PCM) and to describe principal care management services for management of a single high-risk disease.

**CHRONIC CARE MANAGEMENT (CCM)**

***Compelling Evidence***
Chronic care management (CCM) has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, a physician or other qualified health care professional (QHP) while the patient is at home to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before the COVID-19 public health emergency (PHE), was accelerated by the COVID-19 PHE, and will continue after the COVID-19 PHE.

The rapid evolution of sophisticated tools such as remote monitoring apps, patient portals, self-management apps and the ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to provide CCM to patients, since it is primarily a non-face-to-face service. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently implanted sensors, continuous monitoring of vital signs by sensors that can

transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk using CCM so they have time to properly care for those patients who require office visits. This can mean some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as growing evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

Regarding patient communication, data from the Washington University School of Medicine in St. Louis tracking portal over the last four years indicates the numbers of users and logins annually has increased significantly. In 2017, they reported just over 403,000 logins with over 44,000 users. Only two years later in 2019, the logins had increased by 17-fold from 403,000 logins to 6.8 million. Likewise, individual users increased more than six times to over 297,000. Additionally, not only did the number of users increase, but the average login per user more than doubled from nine to 22 during that same time. This translates to a significant increase in data entry and information to review for each patient and this is consistent with practices around the country.

Examples of information shared via patient portals and other methods of electronic communication include messages from case managers, family members, caregivers, and patients who submit information with questions about financial barriers to care, need for durable medical equipment, medication confusion, forms and letter requests. In addition, there is more data to review through this technology. Interoperability of medical records, while undoubtedly facilitating the exchange of information, also increases the amount of data to review in a way that simply did not exist in the past.

In summary, the complexity of CCM has significantly increased since the codes were established and last reviewed by the RUC. The RUC agreed there is compelling evidence that there has been a change in knowledge/technology and patient population for CCM and CCCM services.

***CCM Services***

These services are reported per calendar month with codes differentiated based on the amount of time spent by either the physician personal or by the clinical staff under physician supervision, whichever is greater. The specialty societies indicated that at the beginning of the month, it is not known whether the physician/QHP or the clinical staff will be dedicating greater time to the individual patient management activities. Therefore, the cumulative time and who is performing each of those activities, whether it is clinical staff or whether it is the QHP personally, must be tracked. Regardless of whether the QHP codes or the clinical staff codes are used, there is QHP work taking place. For example, the codes with greater clinical staff time require QHP supervision of the clinical staff. When the QHP personal code is used, there are clinical staff specific activities.

For example, some practices utilize their electronic medical record (EMR) for CCM documentation, which includes a time calculator. The physician submits the management time and indicates whether they as the provider are directly providing that care management with the patient or if the clinical staff is providing this under his/her supervision. It is always assumed clinical staff time is supervised by the QHP. For many patients, the QHP and clinical staff may not meet the calendar month time threshold to report these services, so they do not report them. Therefore, it is only a subset of the patients for whom the threshold is met and the codes reported. At the end of the month a report is generated that indicates which patients have met a certain time threshold, divided out by clinical staff and QHP. Additionally, all the exclusion time will be examined. For instance, time for E/M services on the same date as management services are excluded. There are a series of exclusions to make sure time is not double counted and that time is included on the monthly report. Only after review of the time collated by the report does the QHP determine those which patients might be potentially eligible to report these services, determine and verify that they consented to the services and have a care plan. Only then can the QHP report these services.

Smaller practices might count their time on a spreadsheet, whereas others have more sophisticated time counters that are embedded within their EMR.

***CCM Clinical Staff Services***

**99490** ***Chronic care management services … first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 84 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top reference code 99497 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate* (work RVU = 1.50, 30 minutes intra-service time and 45 minutes total time), noting that the surveyed code requires less physician time and work to perform.

For additional support, the RUC referenced codes 99486 *Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 1.30 and 25 minutes total time) as this ZZZ service requires the same physician time and similar physician work. **The RUC recommends a work RVU of 1.00 for CPT code 99490.**

**99439** ***Chronic care management services … each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure).***
The RUC reviewed the survey responses from 75 physicians and other QHPs and determined the survey 25th percentile work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work. The RUC agreed that code 99439 was in the proper rank order with base code 99490.

The RUC compared the surveyed code to the top two reference codes 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient…*(work RVU = 0.76, 10 minutes intra-service time and 20 minutes total time) and 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* (work RVU = 0.61 and 20 minutes total time), which requires identical time and similar physician work. CPT code 99439 is slightly more intense than 99457, due to the sicker patient population receiving CCM services, having two or more chronic conditions and the QHP is using a care plan to manage the patient. **The RUC recommends a work RVU of 0.70 for CPT code 99439.**

***CCM Physician/QHP Services***

**99491** ***Chronic care management services… first 30 minutes, provided personally by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 55 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 33 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top key reference code 99239 *Hospital discharge day management; more than 30 minutes* (work RVU = 1.90, 30 minutes intra-service time and 55 minutes total time), noting CPT code 99491 requires less physician work and time than 99239, thus is in the proper rank order.

For additional support, the RUC referenced MPC code 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.55 and 45 minutes total time), code 99493 *Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional,…* (work RVU = 2.05 and 36 minutes total time), and code 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure*) (work RVU = 1.40 and 30 minutes total time). **The RUC recommends a work RVU of 1.50 for CPT code 99491.**

**99437** ***Chronic care management services… each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 48 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time.

The RUC compared the surveyed code to the second top key reference service 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 1.40 and 30 minutes total time), which requires the same physician time but more physician work than 99437. The RUC agreed that is appropriate considering that 99498 is a care planning service that is reported when there are family disagreements and multiple family members with whom discussion is needed.

For additional support, the RUC referenced MPC code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99437.**

**COMPLEX CHRONIC CARE MANAGEMENT (CCCM)**

**99487** ***Complex chronic care management services… first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 51 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.81 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top key reference service 99226 *Subsequent observation care, per day, for the evaluation and management of a patient* (work RVU = 2.00, 30 minutes intra-service time and 55 minutes total time), which requires more total physician time and work than 99487, thus is valued appropriately.

For additional support, the RUC referenced MPC code 99235 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU = 1.72 and 44 minutes total time) and

99239 *Hospital discharge day management; more than 30 minutes* (work RVU = 1.90 and 55 minutes total time). **The RUC recommends a work RVU of 1.81 for CPT code 99487.**

**99489** ***Complex chronic care management services… each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 51 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top key reference service 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* (work RVU = 0.61 and 20 minutes total time). The RUC determined that 99489 was in the appropriate rank order based on the intensity, physician work and physician time compared to these services.

For additional support, the RUC referenced MPC code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99489.**

**PRINICPAL CARE MANAGEMENT (PCM)**

***Compelling Evidence***
For 2020, CMS created two G codes for principal care management G2064 *Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities* (work RVU = 1.45) and G2065 *Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities* (work RVU = 0.61), both of which were crosswalked to existing CCM codes 99491 and 99490, respectively. There was no survey conducted and no review by the RUC for these services. The RUC agreed that there is compelling evidence that a flawed mechanism or methodology was used in the previous valuation of the G codes.

In October 2020, the CPT Editorial Panel created four new codes for principal care management (PCM). Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP. The PCM codes differ from the CCM codes in that they are to be reported by physicians or other QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses.

***Physician/QHP PCM***

**99424** ***Principal care management services, for a single high-risk disease… first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 53 physicians and determined the survey 25th percentile work RVU of 1.45 appropriately accounts for the work required to perform this service. The RUC recommends 32 minutes intra-service time. The RUC noted this is in the proper rank order with the recommended work RVU of 1.50 for CPT code 99491 *CCM services by the physician/QHP, first 30 minutes per calendar month*. The principal care management codes are for one single-high risk condition. However, the intensity of managing that high-risk condition is comparable and perhaps higher than managing multiple less urgent, less high-risk chronic conditions.

The RUC compared the surveyed code to the top key reference service 99226 *Subsequent observation care, per day, for the evaluation and management of a patient* (work RVU = 2.00, 30 minutes intra-service time and 55 minutes total time). The RUC agreed that 99424 is valued appropriately compared to this key reference service as 99226 requires almost the same intra-service time but more total time and overall physician work to perform.

For additional support, the RUC referenced MPC codes 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient…* (work RVU = 1.39 and 40 minutes total time) and 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.55 and 45 minutes total time). **The RUC recommends a work RVU of 1.45 for CPT code 99424.**

**99425** ***Principal care management services, for a single high-risk disease… additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 47 physicians and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC agreed that 99425 is a less intense service than base code 99424. The RUC also agreed that the physician work, time and intensity of CPT code 99425 is the same as CPT code 99437 the add-on code for QHP CCM.

The RUC compared the surveyed code to the second key reference code 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 1.40 and 30 minutes total time). The RUC agreed that 99498 requires the same physician time but more physician work and intensity than 99425, which is appropriate considering that 99498 is a care planning service that is reported when there are family disagreements and multiple family members with whom discussion is needed.

For additional support, the RUC referenced MPC code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99425.**

***Clinical Staff PCM***

**99426** ***Principal care management services, for a single high-risk disease… first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 53 physicians and determined the survey 25th percentile work RVU of 1.10 was too high and would place it out of rank order with physician work and time required for CPT code 99490 *Chronic care management services… first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.* Therefore, the RUC recommends a work RVU of 1.00 for CPT code 99426, a crosswalk to CPT 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular*

*probes, each specimen; using computer-assisted technology* (work RVU = 1.00 and 25 minutes total time). The RUC recommends 25 minutes intra-service time for CPT code 99426.

The RUC compared the surveyed code to the second top key reference service 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days* (work RVU = 1.10, 30 minutes intra-service time and 40 minutes total time), noting that the reference code requires more physician time and is less intense than 99426, which involves direct patient care for patients with a deteriorating medical condition over a period of one month.

For additional support, the RUC referenced MPC codes 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time) and 99282 *Emergency department visit for the evaluation and management of a patient…* (work RVU = 0.93 and 19 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99426.**

**99427 *Principal care management services, for a single high-risk disease… each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 51 physicians and determined the survey 25th percentile work RVU of 0.91 was too high and would place it out of rank order with the physician time and work required to perform CPT code 99439 *Chronic care management services … each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure.* Therefore, the RUC recommends a work RVU of 0.71 for CPT code 99427, a crosswalk to CPT 95887 *Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)* (work RVU = 0.71 and 20 minutes total time). The RUC recommends 20 minutes intra-service time.

The RUC compared the surveyed code to the second top key reference service 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days* (work RVU = 1.10, 30 minutes intra-service time and 40 minutes total time), noting 99091 requires more physician time though is less intense than 99427, which involves direct patient care for patients with a deteriorating medical condition over a period of one month.

For additional support, the RUC referenced MPC code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient…* (work RVU = 0.76 and 20 minutes total time). **The RUC recommends a work RVU of 0.71 for CPT code 99427.**

**Practice Expense**
The Practice Expense subcommittee determined that there is compelling evidence that technology and patient/ provider knowledge has changed for the CCM services. The Practice Expense Subcommittee noted that the specialty societies were unable to obtain clinical staff time survey responses for the CCM and PCM services and therefore the recommendations were provided by the specialty societies' expert panel. The Practice Expense Subcommittee voted on a revised spreadsheet with increased minutes for CA021 *Perform procedure/service---NOT directly related to physician work time*. Modifying the CCM codes by increasing the clinical staff time by 25% and the clinical staff times for PCM services to reflect the minimum times to report each service. **The RUC recommends the direct practice expense inputs as modified by the specialty societies.** The PE Subcommittee noted that when these codes come back as part of the New Technology/New Services screen, the specialty societies should conduct a clinical staff survey.

**G Code Deletion**
The RUC recommends that CMS delete G2064 and G2065 as these services may now be reported with CPT codes 99424, 99425, 99426 and 99427.

**New Technology/New Services**
CPT codes 99424-99427 will 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. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.

**Insertion of Interlaminar/Interspinous Device – Tab 26**
**William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Morgan Lorio, MD (ISASS), Kano Mayer, MD (NASS), John Ratliff, MD (AANS), Clemens Schirmer, MD (CNS), and Karin Swartz, MD (NASS)**

**22867** ***Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level***
In May 2015, the CPT Editorial Panel converted two Category III codes to Category I and added two Category III codes to describe the insertion of the interlaminar-interspinous process stability device. At the October 2015 RUC meeting, the RUC agreed that the specialty societies should present CPT codes 22840, 22867 and 22868 at the January 2016 RUC meeting concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression. At the January 2016 RUC meeting, CPT codes 22867 and 22868 were reviewed concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression. CMS did not accept the RUC recommendations for CPT codes 22867 and 22869 at that time. In the NPRM for 2021, CMS received public nomination that code 22867 is potentially misvalued.

In their request, the submitters suggested that the physician work assigned to CPT code 22867 significantly undervalues the procedure relative to the value of CPT code 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* (work RVU=15.37, 90 minutes intra-service time and 362 minutes total time). The submitters stated that the work performed during the surgical steps to perform a laminectomy for both procedures is generally similar except for the additional intensity and complexity involved in code 22867 to implant the interspinous stabilization device. After considering the information provided by the submitter, which suggests that the current valuation for the service may not reflect the level of intensity inherent in furnishing the service relative to other similar services with inputs that exceed those for the nominated service, CMS proposed to nominate CPT code 22867 as potentially misvalued and welcomed public comment on this code**.** The RUC reviewed this service at the January 2021 RUC meeting and supports CMS' analysis that the code is misvalued.

In January 2016, the RUC determined an appropriate work value for code 22867 based on a direct crosswalk to CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00, 90 minutes intra-service time and 270 minutes total time) and noted that both services have similar physician work, identical intra-service time and nearly identical total time. Given these similarities, the RUC recommended a work RVU of 15.00 and further justified this value by comparing 22867 to CPT code 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00, 90 minutes intra-service time and 270 minutes total time). The RUC recommended a work RVU of 15.00 for CPT code 22867. This RUC recommended value considered and accounted for the higher intraoperative intensity of 22867 when compared with similar code 63047 as noted above. However, in the Final Rule for CY 2017, CMS did not accept the RUC recommended work RVU and instead assigned a work RVU of 13.50 based on a crosswalk to CPT code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU=13.50, 90 minutes intra-service time and 276 minutes total time).

The RUC restates its strong support for the initial crosswalk to CPT code 29915. It notes that utilization for code 22867 has been stable the past three years and that the procedure, patient, and technology has not changed since the 2016 valuation. **Therefore, the RUC agrees with the stakeholder societies and recommends that the work RVU recommendation of 15.00 for CPT code 22867 as presented in 2016 be affirmed.**

**Affirm RUC Recommendations**
**The RUC affirms its January 2016 work RVU recommendation of 15.00 for CPT code 22867.**

**Practice Expense**
The Practice Expense Subcommittee reviewed and affirmed the direct practice inputs from January 2016 without modification. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

**Knee Arthroplasty – Tab 27**
**William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS) and Adolph J. Yates, Jr., MD (AAHKS)**

In October 2020, the Relativity Assessment Workgroup identified CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* 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 services within the global period and 2019e Medicare utilization over 10,000. The Workgroup reviewed hospital outpatient claims data to confirm that this service is typically performed in the outpatient setting without any observation or overnight stay. Of 414 carrier line items (from the 5% physician claim files) for CPT code 27446 that were matched to a hospital outpatient claim, just 44 (11 percent) appear to have involved observation care with an overnight stay. The Workgroup noted that CPT code 27446 is a site of service anomaly and visits are currently included in this service that are not typical of what is 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." It is the RUC's understanding that the specialty societies will survey the code family and develop recommendations for presentation at the April 2021 RUC meeting. The RUC notes that the family of services should be identified on the level of interest (LOI). **The RUC recommends that CPT code 27446 be surveyed for April 2021 with the appropriate code family.**

## X. Research Subcommittee (Tab 28)

Doctor Jim Clark, Vice Chair, provided the report of the Research Subcommittee:

- **The Subcommittee reviewed and accepted the October 2020 Research Subcommittee reports.**

The Research Subcommittee report from the October 19th conference call and separate electronic review included in Tab 28 of the January 2021 agenda materials were approved without modification.

- **Compelling Evidence Requirements for Global Period Changes**

During the RUC's other business discussion at the October 2020 RUC meeting, a RUC member noted that when a 010-day or 090-day surgical global code has its global period reduced (090-day to 010-day; 090-day/010-day to 000-day), the RUC does not currently account for the unbundled visits as part of its work neutrality analysis to determine whether a specialty proposal requires compelling evidence; this issue was referred to the Research Subcommittee. On the October 2020 Research Subcommittee call, the Chair provided an initial overview of this topic; the Subcommittee will initiate its discussion of this item at its next meeting held in conjunction with the April 2021 RUC meeting.

**The RUC approved the Research Subcommittee Report.**

## XI. Relativity Assessment Workgroup (Tab 29)

Doctor Margie Andreae, Chair, provided the Relativity Assessment Workgroup report to the RUC. Doctor Andreae indicated that the Workgroup primarily reviewed action plans for codes identified via various screens. A few items were recommended for survey and for the April 2021 meeting.

*Anterior Segment Imaging (92287)*
One issue to be surveyed for April 2021 is CPT code 92287. The specialty societies noted that the CPT Assistant article addressed concerns with the appropriate reporting of macular degeneration. Claims data for 2018 now available indicate 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, correct physician time and valuation. A Workgroup member also commented that 92287 is frequently reported with fluorescein angiography of retina (92235). **The RUC recommends that CPT code 92287 be surveyed for the April 2021 RUC meeting along with any related family codes.**

*Harvard Valued – Utilization over 30,000 (92284)*
The Workgroup identified CPT code 92284 *Dark adaptation examination with interpretation and report* with 2019e Medicare utilization over 30,000. **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).**

*New Technology/New Services*
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 recommends that CPT codes 22869 and 22870 be surveyed for the April 2021 RUC meeting.**

*Transcatheter therapy, embolization (75894)*
Doctor Andreae noted that there was also a re-review of services code, 75894, that the Workgroup had been following along for a couple years. There were some concerns about how this was being reported. The Workgroup found that code 75894 is no longer performed for varicose veins of lower extremities in the majority, professional component only, of these cases. The Workgroup recommended that these services be maintained and removed from this screen. The specialty societies noted that of the 95% of the total 2018 Medicare office claims were reported by only 6 providers**. The RUC requests that CMS investigate this possible incorrect reporting.**

**The RUC approved the Relativity Assessment Workgroup Report. The full report is attached to these minutes.**

## XII. RUC HCPAC Review Board (Tab 30)

Dee Adams Nikjeh, PhD, Co-Chair, provided the report of the RUC HCPAC Review Board to the RUC.

**Co-Chair and Alternate Co-Chair Election**
Richard Rausch, DPT, MBA was elected for a first term as Co-Chair of the HCPAC Review Board. Leisha Eiten, AuD was elected for a first term as alternate Co-Chair of the RUC HCPAC Review Board. Their terms will begin on March 1, 2021.

**Discussion of Final Rule**
The Final Rule was discussed for the remainder of the evening. The Public Health Emergency (PHE), Evaluation and Management (E/M), and telemedicine were the most discussed topics during this discussion. HCPAC members discussed ways to get their members engaged to address the pending 10.2% reduction to the Medicare conversion factor.

## XIII. Administrative Subcommittee (Tab 31)

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

**Review Rotating Seat Election Rules and Candidates Nominated (Tab 33)**
The Administrative Subcommittee reviewed and approved the nominations for the "Any Other" and Internal Medicine rotating seats as well as reviewed the rotating seat policies and election rules. The Subcommittee noted that because there are five candidates for the "Any Other" rotating seat there may be up to three ballots, ranking the top 3 until one candidate obtains a majority vote, as delineated by the RUC Rotating Seat Policies and Election Rules. The Subcommittee noted that "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote", as with the current internal medicine rotating seat election.

Doctor Vates congratulated Daniel DeMarco, MD (Gastroenterology), who will serve on the Internal Medicine rotating seat and Sergio Bartakian, MD (Interventional Cardiology), who will serve on the Any Other rotating seat.

**Permanent RUC Seat Request – AAPM&R**
At the October 2020 RUC meeting, the American Academy of Physical Medicine & Rehabilitation (AAPM&R) formally requested that the RUC create a seat for the specialty of Physical Medicine and Rehabilitation as they believe they meet all five criteria for a permanent seat. The RUC Chair referred this issue to the Administrative Subcommittee for consideration.

*Criteria for Participation - Per the Structure and Functions (III.A(3)), the following are the RUC original criteria for a permanent seat on the RUC listed in priority order:*

1. *The specialty is an American Board of Medical Specialties (ABMS) specialty*
2. *The specialty comprises 1 percent of physicians in practice.*
3. *The specialty comprises 1 percent of physician Medicare expenditures.*
4. *Medicare revenue is at least 10 percent of mean practice revenue for the specialty.*
5. *The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.*

The Structure and Functions also states: "While current membership is not subject to removal based on the above criteria, the RUC will consider new applications for seats based on these criteria."

The Administrative Subcommittee reviewed materials prepared by AMA staff for this meeting, which indicates the status of Physical Medicine and Rehabilitation regarding the five criteria for a permanent seat on the RUC.

1. Physical Medicine and Rehabilitation is an ABMS specialty.

2. Physical Medicine and Rehabilitation comprises 1.18% of physicians in practices from the 2019 AMA Masterfile and 1.20% of physicians in practice based on the CMS count.
3. Physical Medicine and Rehabilitation comprises 1.52% of Medicare expenditures.
4. Physical Medicine and Rehabilitation Medicare revenue is 42.66% of mean practice revenue for the specialty.
5. Physical Medicine and Rehabilitation currently participates on the RUC via the "any other" rotating seat.

The Administrative Subcommittee reviewed the five criteria for a permanent seat on the RUC and agreed that the first four criteria are met without question. Most of the Subcommittee's discussion involved the fifth criterion. Initial questions were raised regarding whether the specialty could claim any codes "as their own" in which they were the dominant provider specialty; 12 codes were found but ultimately discussion determined that this was not really the intent of the fifth criterion. The question was also raised whether the size of the RUC (currently established in the Structure and Functions document at 28 voting seats) could be increased simultaneously, or whether an increase in the voting seats (agnostic of the specialty) require a separate consideration that would qualify as "new business".

The RUC Chair clarified that the question of increasing RUC seats was not an issue and could be managed by staff with changes to the RUC Structure and Functions and the Rules and Procedures documents that would be approved simultaneously with the motion to approve a new permanent member seat. The Subcommittee was directed to make a determination regarding the specialty's request that addressed all five criteria as a block (a motion had been made to approve the first four criteria and then leave the fifth criterion to discussion at the full RUC, but this motion was retracted after the comments of the RUC Chair).

The Subcommittee noted that Physical Medicine and Rehabilitation would offer a different expertise that is not currently represented on the RUC. Physiatrists practice not only in outpatient and inpatient settings, but also in specialized sites of service, such as skilled nursing facilities, long term nursing facilities and rehabilitation facilities, and practice on a unique patient population, the disabled population. Some members of the Subcommittee felt that the society did not offer any additional expertise that was not already available through other societies with a permanent seat on the RUC.

The Subcommittee agreed that Physical Medicine and Rehabilitation can participate currently in the RUC via the "any other" rotating seat, but they are not currently represented by an umbrella organization. The vote was not unanimous, with two members opposed. The Subcommittee discussed whether Physical Medicine and Rehabilitation had "an" umbrella organization other than the American Academy of Physical Medicine and Rehabilitation. No organization other than AAPM&R was identified. The Subcommittee also discussed the terminology of the fifth criterion and notes that the terms are defined "as determined by the RUC". (*The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC*).

**The Administrative Subcommittee agreed that Physical Medicine and Rehabilitation met the five criteria for a permanent seat on the RUC. The Administrative Subcommittee recommended that the RUC consider the addition of Physical Medicine and Rehabilitation as a permanent seat on the RUC.**

Doctor Vates provided the above information and the RUC discussed the fifth criteria for a permanent seat. The RUC noted that the Administrative Subcommittee was charged with discussing and providing a recommendation to the RUC regarding whether a specialty is not meaningfully represented by an umbrella organization. AMA Staff clarified that every recommendation is ultimately approved by the RUC. All actions that come through any of the RUC's Subcommittees or Workgroups provide recommendations to the RUC and the RUC is the final decision maker. Therefore, the Administrative Subcommittee correctly reviewed this item and provided the RUC with a recommendation that PM&R is not currently meaningfully represented on the RUC.

RUC members spoke overwhelmingly in support of adding the unique expertise of PM&R to the RUC as outlined by the Administrative Subcommittee and reiterated at the RUC. The RUC indicated that they do not believe PM&R is currently represented under any umbrella organizations.

**The RUC accepted, by more than a two-thirds vote, that Physical and Rehabilitation met the five criteria for a permanent seat on the RUC, thus will be added as a permanent seat on the RUC.**

**AMA staff worked with OGC staff to formulate the changes required to the RUC Structure and Functions and Rules and Procedures, which were approved by the Administrative Subcommittee.**

**The RUC approved the changes to the RUC Structure & Functions and Rules & Procedures documents, by more than two-thirds, as attached to these minutes.**

**Review RUC Rules and Procedures – Clarification Regarding Appeals**
Doctor Vates indicated that after the April 2020 RUC meeting, an issue was appealed to the RUC. In working through this process, the Administrative Subcommittee Chair and AMA Office of General Counsel (OGC) determined edits to clarify the ad hoc appeals committee formation and appeals process were warranted. **The Administrative Subcommittee recommended edits to the RUC Rules and Procedures as suggested by the OGC. The RUC accepted these changes, by more than a two-thirds vote, as attached to these minutes.**

## XIV. Practice Expense Subcommittee (Tab 32)

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

The Practice Expense (PE) Subcommittee implemented a Consent Calendar to consider 12 tabs that had either standard inputs, affirmations, or no direct PE inputs. Members found the consent calendar to be effective and efficient, thus it will be continued. The Chair encouraged extractions if the specialties or any Subcommittee members deem discussion of the PE inputs is warranted. In addition, the process of modifying and finalizing the PE spreadsheets in real time at the meetings will be continued.

**The RUC approved the Practice Expense Subcommittee Report.**

## XV. RUC Rotating Seat Elections (Tab 33)

Daniel DeMarco, MD, American College of Gastroenterology (ACG)/ American Gastroenterological Association (AGA)/ American Society for Gastrointestinal Endoscopy (ASGE), was elected to the RUC's Internal Medicine rotating seat.

Sergio Bartakian, MD, Society for Cardiovascular Angiography & Intervention (SCAI), was elected to the RUC's Any Other rotating seat.

The term for the rotating seats is two years, beginning in March 2021 and ending in February 2023 with the provision of final recommendations to CMS.

## XVI. AstraZeneca and Janssen SARS-CoV-2 COVID-19 Immunization Administration (Tab 34)

**Jon Hathaway, MD (ACOG), Tanvir Hussain, MD (ACP), Suzanne Berman, MD (AAP), Steven Krug, MD (AAP) and Korinne Van Keuren, DNP, MS, RN (ANA)**

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 (IA) 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.

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 four 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 January 2021, the RUC reviewed the two AstraZeneca SARS-CoV-2 immunization administration codes and in February 2021, the RUC reviewed the Janssen SARS-CoV-2 immunization administration code. 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; 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 will review all non-COVID related immunization codes at the April 2021 RUC meeting.

***AstraZeneca and Janssen SARS-CoV-2 (COVID-19) Immunization Administration***
The RUC reviewed the specialty society recommendations and agreed that 0021A, 0022A and 0031A 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 indicate that patients receiving the second dose are more likely to experience adverse effects and 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 or AstraZeneca immunizations. The RUC recommends the AstraZeneca and Janssen COVID-19 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 0021A,0022A and 0031A.**

**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 Modera IA codes and determined the same direct inputs apply to the AstraZeneca and Janssen 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 similar to other vaccination codes, the typical amount of clinical staff time is higher due 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 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 and Moderna immunization administration codes. The same supplies are recommended for the AstraZeneca and Janssen IA codes with an adjustment to increase to the quantity to *SK057 paper, laser printing (each sheet)* from 1 to 3 sheets. 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 and the EUA for the Moderna COVID VIS is 5 pages. It is anticipated that the AstraZeneca 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 and 0031A).** 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 recommends 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 and Janssen vaccines. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**New Technology/New Services**

The RUC recommends that all COVID Immunization Administration codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A and 0031A) 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.

## XVII. Other Business (Tab 35)

**Reviewer and Pre-Facilitation Process**
The RUC discussed the reviewer and pre-facilitation process and requested that the RUC leadership and staff discuss ways to improve the process to lead to more efficiency and effectiveness. The Administrative Subcommittee will assist, as needed.

**Update to the Summary of Recommendation (SOR) Document**
A RUC member requested that the latest year of RUC review be added to the Summary Spreadsheet. This change will be incorporated for the April 2021 meeting.

**Impact to IWPUT Comparisons**
A RUC member requested that the Research Subcommittee review the impact to IWPUT comparisons based on CMS failure to appropriately incorporate the increases to office visits within services with office visits included in the 010 and 090 global periods. **The RUC agreed to refer this request to the Research Subcommittee to review the impact to IWPUT comparisons.**

**RUC Meeting Improvements**
RUC members discussed improvements made during the virtual meeting format and recommended that staff explore ways to continue these improvements for in-person meetings. Specific examples included the voting methodology and the display and live editing of spreadsheets.

Doctors Peter Smith and Michael Bishop gave their final remarks to the RUC. Doctor Smith concluded the virtual meeting by thanking everyone who is involved in the RUC process and wished everyone luck in the future.

**The RUC adjourned at 5:48 p.m. CT on Saturday, January 16, 2021.**