

**AMA/Specialty Society RVS Update Committee
January 12-15, 2022**

Meeting Minutes

I. Welcome and Call to Order

The RUC met virtually in January 2022 due to the COVID-19 pandemic. Doctor Ezequiel Silva, III called the virtual meeting to order on Thursday, January 13, 2022, at 9:00 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:

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

RUC Alternates:

Amr Abouleish, MD, MBA
Jennifer Aloff, MD
Gregory L. Barkley, MD
Eileen Brewer, MD
Leisha Eiten, AuD
William F. Gee, MD
David C. Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kris Kimmell, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Eileen Moynihan, MD
Sanjay A. Samy, MD
Kurt A. Schoppe, MD
M. Eugene Sherman, MD
James L. Shoemaker, MD
Clarice Sinn, DO
Michael J. Sutherland, MD
Donna Sweet, MD
Mark T. Villa, MD
David Wilkinson, MD, PhD
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

Doctor Silva introduced himself and welcomed everyone to the virtual RUC meeting. He explained the circumstances of the virtual format (live video) that resulted from taking necessary precautions due to the COVID-19 pandemic. Additionally, he reminded participants of RUC confidentiality

provisions, general expectations for the meeting, and highlighted the importance of conference call etiquette.

- Doctor Silva communicated the following guidelines related to confidentiality:
 - All RUC attendees must adhere to the confidentiality agreement that was attested to prior to the meeting.
 - Confidentiality extends to both materials and discussions at the meeting.
 - Recording devices are prohibited.
 - The full confidentiality agreement can be found on the RUC Collaboration site (Structure and Functions).
 - Participants should attend the virtual meeting in a private area.

- Doctor Silva reviewed the financial disclosures:
 - RUC members completed a statement of compliance with the RUC Financial Disclosure Policy.
 - There were no stated disclosures/conflicts for this meeting.

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

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff:
 - Perry Alexion, MD – Medical Officer
 - Arkaprava Deb, MD – Medical Officer
 - Edith Hambrick, MD – Medical Officer
 - 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 several CMS observers were present for the virtual meeting.
 - Julie Adams
 - Anne Blackfield
 - Tamika Brock
 - Larry Chan
 - Kris Corwin
 - Liane Grayson, PhD, MPH
 - Kathleen Kersell
 - Morgan Kitzmiller
 - Scott Lawrence
 - Sarah Leipnik
 - Ann Marshall
 - Patrick Sartini
 - Pam West

- Doctor Silva welcomed the following Contractor Medical Director:
 - Janet Lawrence, MD
- Doctor Silva welcomed the following Members of the CPT Editorial Panel:
 - Jordan Pritzker, MD, MBA – CPT RUC Member
 - Lawrence Simon, MD – CPT Panel Member
 - Chris Jagmin, MD – CPT Panel Vice Chair
- Doctor Silva welcomed the following FDA observer:
 - Douglas E. Kelly, MD – Deputy Center Director for Science, Center for Devices and Radiological Health, U.S. Food and Drug Administration
- Doctor Silva announced departing RUC Members and thanked them for their contributions:
 - Kathleen Cain, MD
 - Timothy Laing, MD
 - Jordan Pritzker, MD
- Doctor Silva announced departing RUC Alternate Members and thanked them for their contributions:
 - M. Eugene Sherman, MD
 - Eileen Moynihan, MD
- Doctor Silva conveyed the Lobbying Policy:
 - “Lobbying” means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
 - Any communication that can reasonably be interpreted as inducement, coercion, intimidation, or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
 - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
 - Full lobbying policy found on Collaboration site (Structure and Functions).
- Doctor Silva announced the RUC reviewer guidelines:
 - To enable more efficient RUC reviews, AMA staff shall review specialty Summary of Recommendation forms (SORs) for adherence to our general guidelines and expectations, such as:
 - Specialty representation
 - Survey methodology
 - Vignette
 - Sample size
 - Budget Neutrality / Compelling evidence
 - Professional Liability Insurance (PLI)
- Doctor Silva shared the following procedural issues for RUC members:
 - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue, and it will be reflected in the minutes.
 - RUC members or alternates sitting at the table may not present or debate for their society.

- Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
- E/M services that are widely performed by most specialties do not require RUC members to recuse themselves from discussion at this meeting. This applies to:
 - Tab 13 Inpatient and Observation Care Services
 - Tab 14 Inpatient Consultations
 - Tab 15 Prolonged Services – on the Date of an E/M
- Doctor Silva 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 single voting link 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 Michael Morrow.
 - RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
 - We vote on every work RVU, including facilitation reports.
 - If members are going to abstain from voting, please notify AMA staff so we may account for all 29 votes.
 - If specialty society presenters require time to deliberate, please notify the RUC Chair.
 - This is the last meeting of the CPT 2023 cycle, all recommendations will be submitted to CMS no later than February 10, 2022, in order to be considered.
- Doctor Silva stated the following procedural guidelines related to RUC Ballots:
 - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.
 - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
 - You must enter the work RVU, physician times and reference codes to support your recommendation.
 - Facilitation Committee meetings are set up for 4pm-6pm via Microsoft Teams if necessary.
- Doctor Silva explained the following RUC established thresholds for the number of survey responses required:
 - Codes with ≥ 1 million Medicare claims = 75 respondents
 - Codes with Medicare claims between 100,000-999,999 = 50 respondents
 - Codes with $< 100,000$ Medicare claims = 30 respondents
 - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Silva shared the process for reviewing Research Subcommittee recommendations:
 - The Research Subcommittee meeting reports are always included in the Research Subcommittee folder.
 - For ease, now you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.
- Doctor Silva conveyed information related to the December 13, 2021, meeting with CMS:
 - Attendees included:

- Meena Seshamani, MD, Deputy Administrator and Director Center for Medicare
- CMS Medical Officers
- Mark Synovec, MD, CPT Chair
- Chris Jagmin, MD, CPT Vice Chair
- Ezequiel Silva, MD, RUC Chair
- Peter Hollmann, MD, RUC Vice Chair
- CMS and AMA Staff
- Discussion included:
 - Collaboration with CMS
 - COVID-19 Coding, valuation for PPE and immunization administration
 - Evaluation and Management changes beyond office visits
 - Valuation of surgical services
 - Surgical global period
 - Clinical staff activities for major surgical procedures
 - Discharge day management following surgery
 - Visit on the same date of surgery
 - Compelling evidence
 - Coding and valuation of physician services utilizing augmented intelligence (AI)

III. Director's Report

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

- Ms. Smith conveyed the following information regarding the RUC Database application:
 - The RUC database is available at <https://rucapp.ama-assn.org>
 - Orientation is available on YouTube at <https://youtu.be/3phyBHWxlms>
 - Accessible both online and offline from any device, including smartphones and tablets
 - Download offline version, you will be prompted whenever there is an update available.
 - Be sure to clear cache and log off before downloading a new version.
 - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
 - Changes to RUC database application include:
 - Addition of 2020 data
 - Billed Together Tab provides and overview of how often codes are billed with other services.
- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process:
 - The RUC Process webinars may be accessed via the RUC Collaboration home page or click “General Resources” from the left navigation bar and then “New to the RUC” and “RUC Process Webinars & Presentations.”
 - The RUC Process webinars may also be accessed directly via the YouTube link: <https://www.youtube.com/playlist?list=PLpUAhDflHfcoS89T0wxivYpHmsYl8fxZp>

- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2024 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Apr 5, 2022	Apr 27-30, 2022	Chicago, IL	CPT 2024
Aug 23, 2022	Sept 21-24, 2022	Chicago, IL	CPT 2024
Dec 13, 2022	Jan 11-14, 2023	Naples, FL	CPT 2024

IV. Approval of Minutes from the October 2021 RUC Meeting

The RUC approved the October 2021 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update

Jordan Pritzker, MD, MBA provided the following CPT Editorial Panel update on the September 2021 Panel meeting, response to the COVID-19 pandemic, and development of AI Taxonomy:

- Panel meeting activity in response to the COVID-19 pandemic
 - The Panel had a busy year creating COVID vaccine codes.
 - The CPT Editorial Panel has approved addition of 28 Category I codes, revised guidelines and parenthetical notes, and updated Appendix Q.
 - Note: Approved at its October 27, 2021, meeting Code 0034A will be used to report Janssen booster vaccine and immunization administration. This code was published on October 27, 2021 and was effective October 20, 2021.
 - The Panel thanks the RUC for their work on immediately reviewing the physician work and practice expense for these new codes.
- September 2021 Panel Meeting – Early Release
 - Tab 50-AI Taxonomy and Tab 82-Audio-only Modifier were approved by the CPT Editorial Panel at its September 2021 meeting. These two issues were made effective on January 1, 2022.
 - These actions will be effective in the CPT code set for 2022.
 - Taxonomy of Artificial Intelligence (AI) for Medical Services and Procedures (Tab 50): an Appendix that will improve the terminology and understanding of AI as it relates to the CPT code set.
- AI Taxonomy
 - Goals of AI Taxonomy:
 - Establish foundational definitions
 - Define elements of differentiation
 - Understood by stakeholders who are not AI experts
 - The AI Taxonomy provides and defines distinct categories to describe the work done by the machine on behalf of the physician based on the effect that it has on the work of the physician/QHP.
 - The DMPAG AI Workgroup is now developing ideas to broaden the reach and understanding of the terminology and concepts in the AI Taxonomy beyond the CPT code set.

- AI Taxonomy – Categorization & Level of Autonomy
 - Assistive: The work performed by the machine for the physician or other qualified health care professional is assistive when the machine detects clinically relevant data without analysis or generated conclusions. Requires physician interpretation and report.
 - Augmentative: The work performed by the machine for the physician or other qualified health care professional is augmentative when the machine analyzes and/or quantifies data in a clinically meaningful way. Requires physician or other qualified health care professional interpretation and report.
 - Autonomous: The work performed by the machine for the physician or other qualified health care professional is autonomous when the machine automatically interprets data and independently generates clinically relevant conclusions without concurrent physician or other qualified health care professional involvement. An autonomous medical service includes interrogating and analyzing data. The work of the algorithm may or may not include acquisition, preparation, and/or transmission of data. The clinically relevant conclusion may be a characterization of data (eg, likelihood of pathophysiology) to be used to establish a diagnosis or to implement a therapeutic intervention. There are three levels of autonomous AI medical services and procedures with varying physician or other qualified health care professional involvement:
 1. The autonomous AI draws conclusions and offers diagnosis and/or management options, is contestable and requires physician or other qualified health care professional action to implement.
 2. The autonomous AI draws conclusions and initiates diagnosis and/or management options with alert/opportunity for override, may require physician or other qualified health care professional action to implement.
 3. The autonomous AI draws conclusions and initiates management, requires physician or other qualified health care professional action to contest.

- AI Taxonomy – Table

Service components	Assistive	Augmentative	Autonomous
Primary Objective	Detects clinically relevant data	Analyzes and/or quantifies data in a clinically meaningful way	Interprets data and independently generates clinically relevant conclusions
Provides Independent diagnosis and/or management decision	NO	NO	YES
Analyzes Data	NO	YES	YES
Requires Physician or other qualified health care professional Interpretation and Report	YES	YES	NO
Examples in CPT code set	Computer-Aided Detection (CAD) Imaging (77048, 77049, 77065-77067, 0042T, 0174T, 0175T)	CGM (95251), external processing of imaging data sets	Retinal Imaging (92229)

- September 2021 Panel Meeting – Early Release: Modifier 93
 - Modifier 93 – Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System:
 - Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

- February 2022 Panel Meeting
 - 38 agenda items Notable items:
 - 3 Digital medicine-related CCAs
 - 13 Category III code applications
 - E/M Cleanup - Editorially revise language throughout the code set for consistency with changes approved in E/M Tabs 6-12 of the February 2021 Panel meeting.
 - Audio-Only Modifier Appendix - Request to establish a listing of codes to allow reporting of Audio Only services Synchronous telemedicine services (Modifier 93).
 - Spinal Neurostimulator Services - Request to:
 - 1) revise Category I codes 63685, 63688, 64590, 64595;
 - 2) add Cat I and III codes 64XX2, 64XX3, 0X43T, 0X44T; and
 - 3) revise and add guidelines and parenthetical notes for implanting, revising, and removal of differing neurostimulator devices.
 - RUC Referral – Tab 12: Intraoperative Cardiac Ultrasound - Establish codes 769X0 and 769X1 to report diagnostic intraoperative epiaortic ultrasound and epicardial cardiac ultrasound.

- CPT Ad Hoc Workgroups
 - Neoplastic Targeted GSP Workgroup
 - Workgroup Charge: The workgroup will review the issues raised in the withdrawn Tab 32 from the May 2020 meeting, "GSP Targeted Panel-Solid Tumor", specifically the feasibility of removing separating DNA and RNA analysis in the procedures captured in codes 81445, 81450, and 81455. And if feasible determine the most appropriate coding solution for these services under the proposed new construct. The necessary stakeholders for the GSP workgroup will be determined after the February Panel meeting.
 - Unlisted Code Workgroup
 - Workgroup Charge: The Workgroup will investigate the use of unlisted codes, specifically how they are used in conjunction with existing Category I and III CPT codes during the same intervention (eg, procedure, analysis), and determine the need for CPT to provide unifying guidance on their appropriate use. If such guidance is recommended, then the Workgroup will provide a draft of such guidance to the Editorial Panel.

- Next Panel Meeting
 - The next Panel meeting is February 3-5, 2022 (Thursday-Saturday).
 - The next application submission deadline is February 11, 2022 (for May 12-14, 2022, meeting).

VI. Washington Update

Bryan Hull, JD, MPH, Senior Attorney, Legislative Affairs, AMA, provided the Washington report focusing on the AMA response to the 2022 Medicare Physician Payment Schedule Final Rule.

- CY 2022 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Final Rule
 - Key proposals:
 - Telehealth and Other Services Involving Communications Technology
 - Clinical Labor Pricing Update
 - Evaluation and Management (E/M) Visits
 - Medicare Quality Payment Program (QPP)
 - The AMA submitted detailed comments in response to the proposed rule.

- CY 2022 Final Rule
 - Telehealth and Other Services Involving Communications Technology
 - AMA strongly supports CMS' decision to extend coverage of services added to telehealth list in response to the PHE through end of 2023.
 - The AMA also recommends telephone E/M codes 99441-99443 be added to this category.
 - Will continue to advocate for the use of these codes.
 - Supports provisions to expand definition of “telecommunications system” for the purpose of telehealth to include audio-only.
 - AMA supports the definition of “direct supervision” include immediate availability through the virtual presence of the supervising physician using real-time, interactive audio/video communications technology be made permanent.
 - Clarification of CMS' Definition of “Home” in 1834(m)
 - CMS clarified that it defines “home” for purposes of 1834(m)(4)(C)(ii)(X) expansively to include temporary lodging such as hotels and homeless shelters. It also includes situations in which a patient “chooses to travel a short distance from the exact home location during a telehealth service.” The AMA has strongly advocated to allow for patients to access telehealth services from wherever they are located.
 - Clinical Labor Pricing Update
 - AMA supports CMS proposal to use the Bureau of Labor Statistics (BLS) wage data.
 - Evaluation and Management (E/M) Visits
 - CMS finalized a split (or shared) visit as an E/M visit in the facility setting, for which “incident to” payment is not available when services are performed in part by both a physician and a non-physician practitioner (NPP).
 - Remote Therapeutic Monitoring
 - CMS is covering the family of 5 remote therapeutic monitoring (RTM) codes as general medicine codes, allowing physicians and other qualified health professionals to bill at their recommended RUC valuation.
 - CMS also designated these codes as “sometimes therapy” codes, which allows use of these codes outside a therapy plan of care when provided by a physician and certain NPPs in appropriate circumstances.

- Medicare Quality Payment Program (QPP)
 - Key Provisions
 - MIPS Value Pathways (MVPs) and Subgroups

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Approved by the RUC April 28, 2022

- Quality Performance Category
 - Complex Patient Bonus
 - Cost Performance Category
 - Improvement Activities Category
 - Promoting Interoperability Category
 - Advanced Alternative Payment Model Incentive Payments
- Surprise Billing
 - The federal No Surprises Act (NSA) prohibits out-of-network health care providers and facilities from balance billing commercially insured patients, in certain circumstances.
 - Out-of-network emergency services provided at a hospital emergency department or independent freestanding emergency department or by air ambulance (but not ground ambulance).
 - Nonemergency care rendered by out-of-network providers at an in-network hospital or ASC unless the patient has consented to be treated by an out-of-network provider and agrees to be balance billed.
 - A series of Interim Final Rules were issued in 2021:
 - July 1, 2021
 - September 30, 2021
 - AMA convened a workgroup of Federation members to identify top NSA advocacy priorities and positions on key issues
 - AMA submitted comments to CMS (QPA comments; IDR comments)
 - Congressional Affairs
 - Several Medicare payment cuts were scheduled to be implemented on January 1, 2022 – 9.75%.
 - President Biden signed into law the Protecting Medicare and American Farmers from Sequester Cuts Act:
 - Delays the Medicare sequester and makes other changes to Medicare payments, and modifies procedures affecting federal budget scorekeeping and federal borrowing
 - Relieves the 2% Medicare “sequestration” cuts
 - Delays the 4% Statutory Pay-As-You-Go (PAYGO) Act cuts
 - Mitigates Medicare physician fee schedule (PFS) cuts.

VII. Centers for Medicare & Medicaid Services Update

Gift Tee, MPH, Director, Division of Practitioner Services, provided the report of the Centers for Medicare and Medicaid Services (CMS) with an overview of the 2022 Physician Fee Schedule (PFS) Final Rule.

- CY 2022 PFS Final Rule Highlights
 - On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2022. Comments on the proposed rule were due by September 13, 2021. Some of the topics covered in the final rule included:
 - CY 2022 PFS Ratesetting and Conversion Factor updates
 - Clinical Labor Pricing Update
 - Evaluation and Management Services

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- Implementation of Certain Consolidated Appropriations Act of 2021 (CAA) Requirements
 - Telehealth and Other Services Involving Communications Technology
 - Therapy Services
 - Vaccine Administration
- CY 2022 Ratesetting and Conversion Factor
 - The CY 2022 PFS final rule presents a series of standard technical changes involving practice expense, including the implementation of the fourth year of the market-based supply and equipment pricing update, changes to the practice expense for many services associated with the finalized update to clinical labor pricing, and standard rate-setting refinements.
 - The Consolidated Appropriations Act of 2021 (CAA) provided a temporary 3.75 percent increase in PFS payments for CY 2021, which expired at the end of CY 2021. This is a statutory provision that CMS does not have regulatory authority to alter.
 - With the budget neutrality adjustment to account for changes in RVUs (required by law), and expiration of the 3.75 percent payment increase provided for CY 2021 by CAA, the finalized CY 2022 PFS conversion factor \$33.59, a decrease of \$1.30 to the CY 2021 PFS conversion factor of \$34.89.
 - Protecting Medicare and American Farmers from Sequester Cuts Act, 2021
 - Following the release of the CY 2022 PFS final rule, the Protecting Medicare and American Farmers from Sequester Cuts Act, 2021, was enacted on December 9, 2021. The law included provisions that resulted in increases in PFS payment amounts effective January 1, 2022, including:
 - Provision of a 3.0% increase in MPFS payments for CY 2022. The new CY 2022 PFS conversion factor is \$34.61
 - Suspension of the 2% payment adjustment (sequestration) through March 31, 2022
 - CMS recalculated the MPFS payment rates and conversion factor to reflect these changes. The revised payment rates are available in the Downloads section of the CY 2022 Physician Fee Schedule [CMS-1751-F | CMS](#) webpage.
 - Clinical Labor Pricing Update
 - CMS shares provider concerns regarding the need to ensure continued access to quality and affordable care for all beneficiaries in physician office and hospital settings. The statute requires us to set budget-neutral payment for services under the PFS based on relative resource costs incurred by practitioners when furnishing services to Medicare beneficiaries. To accomplish this, it is necessary periodically to update the information on which we base these costs. For instance, we initiated an update to our supply and equipment pricing data four years ago and are completing a transition to full use of the updated data this year. In contrast, we last updated the clinical labor costs using Bureau of Labor Statistics (BLS) data and other supplementary sources under the Medicare PFS 20 years ago, which means that current payments may not appropriately reflect current labor costs the same way they reflect supply and equipment pricing. Stakeholders have raised concerns that the long delay since clinical labor pricing was last updated has created a significant disparity between CMS' clinical wage data and the market average for clinical labor rates.
 - In consideration of stakeholder comments, we finalized our proposal to update the clinical labor rates for CY 2022 using a four-year transition period. We have used a four-

year transition to incorporate new pricing data in the past and we believe that the use of a phased transition will help provide payment stability and maintain beneficiary access to care.

- We recognize that as we update the clinical labor pricing data, payment for some services will be reduced due to PFS budget neutrality requirements. These services include proportionally more supplies and equipment than clinical labor in their overall cost. However, other services, such as those primarily furnished by family practice and internal medicine specialties, involve proportionally more clinical labor, will be positively affected by the pricing update.
 - We note that payment rates for these services were reduced due to recent market-based supply and equipment pricing updates and the same PFS budget neutrality requirements. We anticipate that a payment increase for these services will increase access to care for disadvantaged groups and underserved communities. We believe that using a four-year transition in implementing the clinical labor pricing update will help maintain payment stability and mitigate potential negative effects on health care providers by gradually phasing in the changes over some time.
 - We appreciate any additional information that stakeholders can supply both in terms of direct wage data, as well as to identify the most accurate types of BLS categories that could be used for clinical labor pricing. We will continue to consider additional pricing data that can be used to update the clinical labor rates during the remaining three years of the transition period.
 - Overall, we believe that CMS's efforts to improve pricing accuracy would improve the sustainability of the PFS and the broader health system, improve access to care, and reduce inequitable disparities. We believe that the ongoing market trends, including market consolidation, site of service differentials and use of innovative technology in the practice of medicine highlight the need to update the overall PFS practice expense input data comprehensively, including a full accounting of indirect/overhead costs, to account for changes in the delivery of health care, especially with regards to independent versus facility-based practices.
- Evaluation and Management (E/M) Services
 - For CY 2022, we are clarifying and refining policies that were reflected in Medicare manual instructions that were recently withdrawn. Specifically, we are making a few refinements to our current policies for split (or shared) E/M visits, critical care services, and services furnished by teaching physicians involving residents.
 - Split (or Shared) Visits
 - We defined split (or shared) visits as an E/M visit in the facility setting that is performed in part by both a physician and a NPP who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment will be made to the practitioner who performs the substantive portion of the visit.
 - Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.
 - Beginning in 2023, the substantive portion of the visit will be defined as more than half of the total time spent by the physician and NPP. For 2022, the substantive portion can be one of the 3 key components (history, physical exam, or medical decision-making), or more than half of the total time (except for critical care, which can only be more than half of the total time).

- Split (or shared) visits can be reported for new and established patients, initial and subsequent visits, and prolonged services.
- Modifier -FS should be included on the claim to identify these services to inform policy and help ensure program integrity.
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.
- Critical Care Services – Concurrent and Shared
 - When medically necessary, critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty.
 - Critical care services can be furnished as split (or shared) visits.
- Critical Care Services and Other Same-Day Visits
 - Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care.
 - The visit must be medically necessary, and the services must be separate and distinct, with no duplicative elements from the critical care service provided later in the day. Practitioners must report modifier -25 on the claim.
- Critical Care Services and Global Procedures
 - Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure.
 - Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases).
 - New modifier -FT should be included on the claims to identify that the critical care is unrelated to the procedure.
 - If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care.
- Teaching Physician Services (Visit Level Selection)
 - We clarified that when time is used to select the E/M visit level, only the time of the teaching physician may be included (including, but not limited to time spent being present with the resident. Time spent independently by the resident cannot be included.
 - Under the primary care exception, for visits allowing medical decision-making (MDM) or time to be used for visit level selection, only MDM can be used to select visit level. This will help ensure appropriate coding to reflect the total medically necessary time.
- Implementation of Additional Consolidated Appropriations Act (CAA) (2021) Requirements
 - Coinsurance for Colorectal Cancer Screening
 - CMS finalized the implementation of Section 122 of the CAA, which provides a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services (e.g., removal of polyps). The provision calls for a

- gradual phase down of beneficiary coinsurance liability from 20 percent, beginning in CY 2022 and completing in CY 2030 at 0 percent.
- Billing for Physician Assistant (PA) Services
 - CMS is implementing section 403 of the CAA, which authorizes Medicare to make direct payment to PAs for professional services that they furnish under Part B beginning January 1, 2022. Medicare currently can only make payment to the employer or independent contractor of a PA. Beginning January 1, 2022, PAs may bill Medicare directly for their professional services, reassign payment for their professional services, and incorporate with other PAs and bill Medicare for PA services.
- Telehealth and Other Services Involving Communications Technology
 - Mental Health (CAA)
 - Section 123 of the CAA removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE for COVID-19.
 - Also, the CAA prohibits payment for a mental health service via telehealth unless the physician or practitioner furnishes an item or service in-person first, without the use of telehealth, within six months before the first time they furnish a telehealth service to the beneficiary, and thereafter, subsequent in-person services at such times as the Secretary determines appropriate.
 - We are finalizing a requirement for an in-person visit within twelve months of subsequent mental health telehealth services, and we are finalizing that exceptions may be made based on beneficiary circumstances with the reason documented in the patient’s medical record. In addition, the CAA added rural emergency hospitals to the list of permissible telehealth originating sites, effective beginning in CY 2023.
 - Audio-only
 - We are finalizing a revision to our regulatory definition of “interactive telecommunications system” to permit use of audio-only communications technology under certain circumstances for mental health services provided via telehealth to beneficiaries who are in their homes.
 - We are finalizing a requirement for documentation in the medical record of the reason for using audio-only technology.
 - Additions to the Telehealth List
 - We are finalizing a revised timeframe for inclusion of certain services added to the telehealth list on a temporary basis, extending from the current December 31, 2021, timeline to December 31, 2023.
 - We are finalizing that certain cardiac and intensive cardiac rehabilitation codes, specifically CPT codes 93797 and 93798 and HCPCS codes G0422 and G0423, continue to be available through Medicare Telehealth on a temporary basis, until the end of December 2023.
 - Communication Technology-Based Service (CTBS) Policies (including audio-only code)
 - Based on support from commenters we are finalizing our proposal to permanently adopt coding and payment for HCPCS G2252 (a longer (11-20 minute) virtual check-in visit) as described in the CY 2021 PFS final rule.

- Therapy Services
 - CMS is completing the implementation of section 53107 of the Bipartisan Budget Act of 2018, which requires CMS, through the use of new modifiers (CQ and CO), to identify and make payment at 85% of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by therapy assistants (PTAs) and occupational therapy assistants (OTAs) — when they are appropriately supervised by a physical therapist (PT) or occupational therapist (OT), respectively.
 - CMS defines services furnished in whole or in part by PTAs or OTAs as those for which the PTA or OTA time exceeds a de minimis threshold. For CY 2022, in response to numerous stakeholder questions and to promote proper therapy care, CMS is revising the policy for the de minimis standard. Specifically, CMS’ revised policy would allow a 15-minute timed service to be billed without the CQ/CO modifier in cases when a PTA/OTA participates in providing care to a patient, independent from the PT/OT, but the PT/OT meets the Medicare billing requirements for the timed service on their own, without the minutes furnished by the PTA/OTA, by providing more than the 15-minute midpoint (that is, 8 minutes or more — also known as the 8-minute rule). Under this finalized policy, any minutes that the PTA/OTA furnishes in these scenarios would not matter for purposes of billing Medicare.
 - In addition to cases where one unit of a multi-unit therapy service remains to be billed, we revised the de minimis policy that would apply in a limited number of cases where there are two 15-minute units of therapy remaining to be billed. For these limited cases, CMS is allowing one 15-minute unit to be billed with the CQ/CO modifier and one 15-minute unit to be billed without the CQ/CO modifier in billing scenarios where there are two 15-minute units left to bill when the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of the same service when the total time is at least 23 minutes and no more than 28 minutes.
 - Overall, the de minimis standard would continue to be applicable in the following scenarios:
 - When the PTA/OTA independently furnishes a service, or a 15-minute unit of a service “in whole” without the PT/OT furnishing any part of the same service.
 - In instances where the service is not defined in 15-minute increments including: supervised modalities, evaluations/re-evaluations, and group therapy.
 - When the PTA/OTA furnishes 8 minutes or more of the final 15-minute unit of a billing scenario in which the PT/OT furnishes less than eight minutes of the same service.
 - When both the PTA/OTA and the PT/OT each furnish less than 8 minutes for the final 15-minute unit of a billing scenario (the 10 percent standard applies).
- Vaccine Administration
 - Payment for administration of the influenza, pneumonia and hepatitis B preventive vaccines has historically been based on a crosswalk to a code on the PFS. This method resulted in a decrease in the payment rate over the past several years, which was a source of concern within the healthcare community particularly with the onset of the COVID-19 pandemic. Based on the history of payment for vaccine administration and the feedback we received in response to our comment solicitation, in the final rule we took action to update the payment rates for the administration of Part B preventive vaccines.
 - Effective January 1, 2022, CMS will pay \$30 per dose for the administration of the influenza, pneumococcal and hepatitis B virus vaccines.

- This new payment rate is nearly double the rate that Medicare has paid during the past few years.
 - In addition, CMS will maintain the current payment rate of \$40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends. Effective January 1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.
 - CMS will continue the additional payment of \$35.50 for COVID-19 vaccine administration in the home under certain circumstances through the end of the calendar year in which the PHE ends.
 - We believe that this extension will maximize access to COVID-19 vaccines for homebound beneficiaries as conditions gradually return to normal following the end of the PHE.
 - CMS will continue to pay for COVID-19 monoclonal antibodies under the Medicare Part B vaccine benefit through the end of the calendar year in which the PHE ends. During this interim time, we will maintain the \$450 payment rate for administering a COVID-19 monoclonal antibody in a health care setting, as well as the payment rate of \$750 for administering a COVID-19 monoclonal antibody therapy in the home.
 - Effective January 1 of the year following the year in which the PHE ends, CMS will pay physicians and other suppliers for COVID-19 monoclonal antibody products as biological products paid under section 1847A of the Act; health care providers and practitioners will be paid under the applicable payment system, and using the appropriate coding and payment rates, for administering COVID-19 monoclonal antibodies similar to the way they are paid for administering other complex biological products.
 - We believe that the public health needs that prompted coverage of these products as vaccines will gradually restabilize following the end of the PHE, and that extending the current payment approach to the end of the year will give healthcare providers adequate time to prepare for the change in payment methodology while continuing to maximize access to beneficiaries.
- Mr. Tee addressed questions from the attendees:
 - A RUC member inquired about the split/shared regulations that were issued and how CMS is planning to issue clarifications via rulemaking. The RUC member provided a few examples of questions that currently exist and requested that clarity be provided prior to formal rulemaking as they have an impact on day-to-day care:
 - Clarity is needed around how short an attestation can be when a physician is trying to describe their medical decision making in 1-2 sentences (e.g., surgery, electrophysiology, chemotherapy, etc.) to demonstrate that it was the substantive part of the visit.
 - Clarity is also needed when a cancer patient comes in for preparatory work prior to surgery in a single day and sees their oncologist, primary care physician, and their surgeon, in addition to seeing three nurse practitioners in each specialty who perform a substantive portion of medical decision making. Those subsequent claims will go in with a single specialty of nurse practitioner, and only the first claim would be paid.
 - Mr. Tee stated that clarity would have to be provided in the form of rulemaking.

VIII. Contractor Medical Director Update

Janet I. Lawrence, MD, MS, FACP, Medicare Contractor Medical Director (CMD), provided the CMD update covering active workgroups, Artificial Intelligence (AI), amniotic products, and dental services.

- Workgroup Updates
 - MACs continue to work collaboratively to ensure the most uniform coverage nationwide.
 - Prioritization Workgroup (WG) that receives input from all MACs and then ranks and recommends potential areas for collaborative Local Coverage Determinations (LCDs).
 - Activity of any given work group varies, depending on where it's in the LCD development cycle.
- Workgroups
 - At present the most active workgroups are:
 - Pricing
 - Pain management
 - Artificial Intelligence (AI)
- Potential Workgroups
 - Bioengineered skin substitutes
 - Remote physiologic Monitoring (will revisit after PHE)
 - Possible Complex Drug Administration LCDs (in addition to present billing and coding Local Coverage Article (LCA))
- Artificial Intelligence
 - AI work group continues meeting to understand and define appropriate clinical uses for this technology.
 - Currently, group looking to AMA to update or expound upon definition of such terms as “automated” within AMA’s digital health and/or augmented intelligence policies so work group’s products are consistent with AMA definitions.
 - Work group developing criteria for “umbrella policy” to govern developing algorithms and AI.
 - With a goal of policy by end of third quarter of 2022.
 - Once “umbrella policy” is complete, the goal is to develop technology-specific LCDs as data indicate.
 - Plans for the workgroup to have separate meetings with AMA collaboration on a quarterly basis in order to maintain confidentiality where needed.
 - CMS/MAC collaborators will continue to meet monthly and as needed.
- Amniotic Products
 - Continue to be problematic.
 - Confusion as to which amniotic products follow FDA 351 pathway and which ones are true 361 products.
 - Injectable amniotic products are Not FDA approved for anything!
 - These products used in many settings for wide range of diagnoses.
 - Food and Drug Administration (FDA) clarified that all reconstituted and/or injectable amniotic and placental derived products, for any use, are regulated under section 351 of the Public Health Service Act (PHS Act) and/or the Federal, Food, Drug, and Cosmetic Act.

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Approved by the RUC April 28, 2022

- To be considered HCT/P's (and be regulated under the 361 pathway), product must meet 4 criteria. Products must be:
 - Minimally manipulated
 - Intended for homologous use
 - Not combined with another article
 - Without a systemic effect
- Dental Services
 - SSA §1862(a)(12) states that no payment may be made for services relating to the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made for inpatient hospital services because of underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization with the provision of such services.
 - 42 CFR § 411.15 - Particular services excluded from coverage
 - Dental services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, except for [inpatient hospital](#) services in connection with such dental procedures when hospitalization is required because of:
 - The individual's underlying medical condition and clinical status; or
 - The severity of the dental procedures.
- Dental Radiologists
 - Dentists as part of their training are qualified to read dental x-rays.
 - Dental radiology is newer dental specialty recognized by the American Dental Association.
 - It is accredited by the American Academy of Oral and Maxillofacial Radiology.
- Dental Codes
 - CR 11934 CPT Codes of Concern:

CPT Code	Definition
21079	Impression and custom preparation; interim obturator prosthesis
21080	Impression and custom preparation; definitive obturator prosthesis
21085	Impression and custom preparation; oral surgical splint
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)

- Dental Services
 - Individual claims review of procedures billed as dental services are being inappropriately paid, it was discovered that several of the southern California dentists included dental X-Ray/CT scan reports read by a dental radiologist.
 - CR 11934 went into effect December 2020 to prevent inappropriate use of certain CPT codes with some ICD 10 diagnosis codes for dental services.
 - In reviewing the X-Ray/CT scan reports read by these dental radiologists, verbiage was used that would easily allow dental providers to bill ICD 10 codes which would allow payment for dental services that would likely otherwise be noncovered.

- References for this presentation
 - Social Security Act (SSA) §1862(a)(12)
 - 42 Code of Federal Regulations (CFR) § 411.15

IX. Relative Value Recommendations for CPT 2023

Removal of Sutures or Staples (Tab 4)

Charles Mabry, MD (ACS), Anne Miller, MD (ASSH), Guy Orangio, MD (ASCRS), Don Selzer, MD (ACS), Steve Sentovich, MD (ASCRS) and Ketan Sheth, MD (SAGES)

Facilitation Committee #3

In October 2021, the CPT Editorial Panel approved the deletion of CPT code 15850 and revision of CPT code 15851 to clarify the intent of the phrase "requiring anesthesia" included in the code descriptor. Specifically, code 15851 may only be reported for suture/staple removal requiring general anesthesia or moderate sedation. These codes were also revised to allow reporting by any physician that performs suture/staple removal under general anesthesia or moderate sedation in the facility setting, even within a global period, as this would be covered as a take-back to the operating room and reported with an appropriate modifier.

In addition, two new add-on CPT codes, 15853 and 15854, were established for reporting the practice expense (PE) related to suture/staple removal when not inherent to a procedure code (ie, 000-day global codes). For the non-facility setting (eg, office, home), these add-on codes may only be reported in conjunction with an office visit E/M code to account for only the additional practice expense related to suture/staple removal and not the work related to the E/M service. It was noted that for 10-day and 90-day global codes, if the suture/staple removal were performed by a different provider not in the same group, then the related practice expense would be included in the payment for transferred postoperative care only using modifier–55.

Compelling Evidence (CPT Code 15851)

The RUC reviewed, and agreed, that flawed methodology was used in the previous valuation of this service. CPT code 15851 is a Harvard-based code. Fifteen plastic surgeons reviewed this code with a 30-day global period during the Harvard study. Pediatric surgeons, the likely provider of this service, were not included in the Harvard study. The RUC noted that the pre- and post-times that were assigned by the Harvard algorithm may have underestimated the total time by not including positioning time or scrub, dress, wait time resulting in an underestimation of relative physician work. Therefore, the RUC agreed that the Harvard study estimated times for this service are not valid for comparison to the current RUC survey. In addition, the Final Rule for the 1992 Medicare Physician Payment Schedule indicated the global period was 000-day, not 030-day, and the source of the work RVU was indicated as “established by HCFA,” not the Harvard study. The specialties also noted that there was prior miscoding of CPT code 15851 for suture removal in the office, and it was clear that “anesthesia other than local” and the intent of CPT code 15851 was misunderstood. **The RUC concurred that there is compelling evidence to support a change in physician work for CPT code 15851 based on flawed methodology.**

15851 Removal of sutures or staples requiring anesthesia (i.e., general anesthesia, moderate sedation)

The RUC reviewed the survey results from 131 surgeons and determined that the survey median work RVU somewhat overestimated and the survey 25th percentile underestimated the physician work typically required to perform this service. The RUC also discussed the pre-service times and

considered the challenges of selecting the correct pre-time package for this service. Ultimately, the committee agreed that the physician times from the robust survey should be supported with the exception of a decrease of 10 minutes in pre-service evaluation time for this post-operative procedure. The RUC agreed that pre-service time package 2 was appropriate with the amended survey times recommended: 10 minutes evaluation, 3 minutes positioning, 10 minutes scrub/dress/wait time, 15 minutes intra-service time, 15 minutes immediate post-service time. The RUC reiterated that the current times for this service are from the Harvard study and not valid for comparison.

The RUC recommends a direct work RVU crosswalk to CPT code 50431 *Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access* (work RVU= 1.10, 15 minutes intra-service time and 55 minutes total time), noting that both services involve an identical amount of intra-service time, identical amount of post-service time and similar total time. Further, it was noted that the crosswalk value falls appropriately between the survey median and 25th percentile and reflects a relative value of 15851 when compared with code 50431.

The RUC concurred that the recommended work RVU of 1.10 for CPT code 15851 is appropriately bracketed by the top key reference service MPC code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01, 15 minutes intra-service time and 36 minutes total time) and MPC code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU= 1.14, 15 minutes intra-service time and 27 minutes total time) and, additionally, CPT code 93283 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system* (work RVU= 1.15, 15 minutes intra-service time and 35 minutes total time). The RUC concluded that CPT code 15851 should be valued based on a direct work RVU crosswalk to CPT code 50431 which falls between the survey median and 25th percentile. **The RUC recommends a work RVU of 1.10 for CPT code 15851.**

Practice Expense

CPT code 15851 is now a facility-only code and CPT codes 15853 and 15854 are non-facility PE-only add-on codes. The Practice Expense (PE) Subcommittee considered and supported compelling evidence for code 15851 as it has not been previously reviewed for direct inputs in the facility. The code family was reviewed by the PE Subcommittee and the direct practice expense inputs were approved as submitted by the specialty societies without modification. The PE Subcommittee discussed the potential for a change in specialty from surgical to primary care and therefore requested that the codes be re-reviewed in three years. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

Relativity Assessment Workgroup Review

The RUC recommends that the Relativity Assessment Workgroup review CPT codes 15853 and 15854 when three years of claims data are available to assess if there is a shift in the specialty performing these services.

Total Disc Arthroplasty (Tab 5)

Hussein Elkousy, MD (AAOS), John Ratliff, MD (AANS), Clemens Schirmer, MD (CNS) and Karin Swarts, MD (NASS)

In September 2021, the CPT Editorial Panel created Category I code 22860 to describe *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)* and replace Category III code 0163T, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)*. CPT codes 22860 and 22857, *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar* were surveyed for the January 2022 RUC meeting.

The specialty societies surveyed codes 22860 and 22857 for the January 2022 RUC meeting. The survey was sent to a random sample of members from five specialty societies with a total of 48 respondents. In reviewing the survey responses for code 22857, the specialties noted, and the RUC concurred that the collected data was inaccurate for several suspected reasons. The survey results indicated a median intra-service (i.e., skin-to-skin) time of 120 minutes which immediately suggested to the specialty societies, and RUC members familiar with this service, that the survey results were inaccurate. It is likely that survey respondents were unfamiliar with the procedure as it is very low volume and generally takes much longer than 120 minutes to perform the intra-service work. The RUC concludes that the survey respondents only accounted for the work of the orthopaedic or neurosurgeon and did not account for the additional co-surgeon that routinely performs part of the intra-service work for this procedure. Those familiar with this procedure further indicated that respondents likely did not account for the time spent performing the approach and closure, which is typically performed by a second surgeon. Furthermore, the standard survey tool used for this survey did not include specific instructions regarding the skin-to-skin related work by each surgeon, and this likely contributed to respondents inaccurate reporting of skin-to-skin time. Therefore, after thorough review, the specialty societies indicated, and the RUC agreed, that the survey results for both CPT codes 22857 and 22860 were erroneous and that the codes should be resurveyed for the April 2022 RUC meeting with a targeted survey tool that has been reviewed and approved by the Research Subcommittee. **The RUC recommends an interim work RVU of 27.13 for CPT code 22857 and contractor pricing for CPT code 22860. The specialty society will resurvey for the April 2022 RUC meeting and work with the RUC's Research Subcommittee to draft a targeted survey.**

Practice Expense

The RUC recommends the current direct practice expense inputs for CPT codes 22857 and 22860. The specialty society will resurvey for the April 2022 RUC meeting.

Percutaneous Arteriovenous Fistula Creation (Tab 6)

Curtis Anderson, MD (SIR), Wayne Causey, MD (SVS), Stephen Clyne, DO (RPA), Lauren Golding, MD (ACR), Minhaj Khaja, MD (SIR) and Matthew Sideman, MD (SVS)

In October 2021, the CPT Editorial Panel created two new Category I CPT codes (36836 and 36837) to describe the creation of an arteriovenous fistula in an upper extremity via a percutaneous approach. Previously, CPT coding did not account for percutaneous arteriovenous access creation, as current CPT codes 36818, 36819, 36820, and 36821 only describe an open surgical approach. Given that new technologies have been developed that allow for less invasive approaches that utilize percutaneous image-guided methods to approximate a target artery and vein using magnets or mechanical capture, CMS had created two temporary HCPCS G-codes (G2170 and G2171) in July 2020 that describe two

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approaches to percutaneous arteriovenous access creation. The most significant material difference between these procedures is that G2170 requires two catheters from two different percutaneous access sites, one in the vein and one in the artery that are then approximated using magnets, while G2171 requires a single percutaneous access that then connects the artery and the vein under ultrasound guidance and then uses mechanical capture for approximation. Both procedures may require flow directing techniques and intra-procedural guidance, including arteriography or venography, depending on the vascular anatomy and the choice of the physician or operator.

CPT codes 36836 and 36837, which represent two percutaneous approaches to creating arteriovenous access for End-Stage Renal Disease (ERSD) patients during hemodialysis, are intended to replace HCPCS codes G2170 and G2171, both of which the RUC have submitted for deletion by CMS. Both 36836 and 36837 were surveyed by a random sample of diagnostic and interventional radiologists, as well as nephrologists and vascular surgeons for the January 2022 RUC meeting.

36836 Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation

The RUC reviewed the survey results from 37 physicians and recommends the survey 25th percentile work RVU of 7.50 for CPT code 36836. The RUC recommends 15 minutes of pre-service evaluation time, 5 minutes positioning time, 6 minutes scrub/dress/wait time, 60 minutes of intra-service time, and 18 minutes of immediate post-service time. The specialties noted that the 26 minutes of pre-service time accounts for diagnostic imaging retrieval and review, in addition to preoperative preparation and positioning. The recommended 15 minutes of pre-service time is 3 minutes less than the 18 minutes of pre-service time in the pre-service package and median time, and the RUC found that to be appropriate. Additionally, the RUC agreed with the recommended increase from 1 to 5 minutes of positioning time given the importance of proper positioning and demarcation of the venous access site in this procedure and other similar upper extremity procedures utilizing ultrasound guidance. The RUC determined that the physician work and time maintain relativity to open arteriovenous anastomosis codes (36818-36821).

The RUC compared the surveyed code to the top key reference service and Multi-Specialty Points of Comparison (MPC) code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes of intra-service time, and 141 minutes total time) and noted that the survey code typically involves less intra-service and total time, and even though it is slightly more intense to perform, it involves less physician work overall. The RUC noted that 75 percent of those that selected the top key reference code had indicated that the surveyed code is more intense and complex to perform and the RUC recommendation appropriately accounts for this difference in intensity. The RUC also compared the surveyed code to the second top key reference service and MPC code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU = 9.00, 75 minutes of intra-service time, and 126 minutes total time) and again determined that CPT code 36836 requires less

physician work and time to perform, thus appropriately valued lower. The RUC concluded that CPT code 36836 should be valued at the 25th percentile work RVU as supported by the survey.

For additional support, the RUC referenced the MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, 60 minutes of intra-service time and 133 minutes of total time) and noted that it is a reasonable comparator code to 36836. MPC code 52353 exactly matches the intra-service time of the survey code and closely aligns in terms of total time and intensity of physician work. **The RUC recommends a work RVU of 7.50 for CPT code 36836.**

36837 Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation

The RUC reviewed the survey results from 39 physicians and recommends the survey 25th percentile work RVU of 9.60 for CPT code 36837. The RUC recommends 15 minutes of pre-service evaluation time, 5 minutes positioning time, 6 minutes scrub/dress/wait time, 75 minutes of intra-service time, and 18 minutes of immediate post-service time. The RUC determined that the pre-service time for 36837 should be the same as CPT code 36836. This is because the need for diagnostic imaging retrieval and review, as well as preoperative preparation and positioning, is identical to the work associated with the procedure in code 36836. The specialties noted that the 26 minutes of pre-service time accounts for diagnostic imaging retrieval and review, in addition to preoperative preparation and positioning. The recommended 15 minutes of pre-service time is 3 minutes less than the 18 minutes of pre-service time in the pre-service package and median time, and the RUC found that to be appropriate. Additionally, the RUC agreed with the recommended increase from 1 to 5 minutes of positioning time given the importance of proper positioning and demarcation of the venous access site in this procedure and other similar upper extremity procedures utilizing ultrasound guidance. The RUC again determined that the physician work and time maintain relativity to open arteriovenous anastomosis codes (36818-36821).

The RUC compared the surveyed code to the top key reference service and MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes of intra-service time, and 141 minutes total time) and noted that the survey code typically involves less intra-service and total time, and even though it is more intense to perform, it involves less physician work overall. The RUC noted that 90 percent of that selected the top key reference code had indicated that the survey is more intense and complex to perform and the RUC recommendation appropriately accounts for this difference in intensity. The RUC compared the surveyed code to the second top key reference service and MPC code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU = 9.00, 75 minutes of intra-service time, and 126 minutes total time) and recognized that the intra-service time of KRS 36905 is an exact match to the survey code. The RUC further determined that the recommendation for 36837 accounts for the increased level of intensity in

the physician work and concluded that 25th percentile work RVU was appropriate and supported by the survey. Furthermore, the survey code RVU is properly bracketed by the top two key reference services in terms of their work RVU. **The RUC recommends a work RVU of 9.60 for CPT code 36837.**

Practice Expense

The Practice Expense (PE) Subcommittee discussed the new supply and equipment items recommended for these services. The two new supply inputs are the procedure specific catheters for the individual codes, the Ellipsys catheter/device (36836) and the Wavelinq catheters/device (36837). These items are required to create the arteriovenous anastomosis during the procedures. Two new equipment inputs are recommended that correspond to the industry specific/procedure specific RF generators for these catheters, the Ellipsys Generator, and the Wavelinq Generator. These generators can only be used for this specific service. The PE Subcommittee noted the high cost of the two new supply inputs and reiterates its previous request to CMS:

The RUC calls on CMS to separately identify and pay for high-cost disposable supplies. The RUC makes this recommendation to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies, but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty. If high cost supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool. **The RUC recommends that CMS separately identify and pay for high-cost disposable supplies priced in excess of \$500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

In addition, it was clarified that EF019 *stretcher chair* is needed on hand in the ultrasound room for preoperative and postoperative sedation and recovery. The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Service

The RUC recommends that CPT codes 36836 and 36837 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Recommendation to Delete G2170 and G2171

The RUC recommends that CMS delete both G2170 *Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed* and G2171 *Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, enography, and/or ultrasound, with radiologic supervision and interpretation, when performed.*

Energy Based Repair of Nasal Valve Collapse (Tab 7)

Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)

In September 2021, the CPT Editorial Panel created Category I code 30469 to report *Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling* which is currently reported with an unlisted code. For the January 2022 RUC meeting, both CPT code 30469 and family code 30468 *Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)* were reviewed.

30468 Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)

The RUC reviewed the specialty society request to affirm the recent RUC valuations for CPT code 30468. Although this code was identified with the new code to be surveyed, the specialty society elected not to survey because the code was recently surveyed and valued by the RUC in January 2020. Additionally, there are no changes to the code descriptor or related work to perform this service. **The RUC recommends affirming a work RVU of 2.80 for CPT code 30468.**

30469 Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling

The RUC reviewed the survey results from 82 otolaryngologists and recommends a work RVU of 2.70 based on a direct work RVU crosswalk to CPT code 31295 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa* (work RVU = 2.70, 20 minutes intra-service time, and 56 minutes total time). This valuation maintains relativity in comparison to family code 30468 as well as other 000-day global otolaryngology codes within the Medicare Physician Payment Schedule (MFS). The RUC recommends 17 minutes of pre-service evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, and 10 minutes immediate post-service time. The post service package was reduced to as to not exceed survey median data.

The original CPT coding change application (CCA) brought forth by industry stated this service was primarily performed in the hospital outpatient setting. After discussion, the RUC determined that this service is typically performed in an office setting under local anesthesia, which differs from the CCA, but was the consensus of those who routinely perform the service. Based on this determination, and to maintain relativity, the RUC determined that the survey 25th percentile work RVU of 2.80 was not appropriate because it is the same value as CPT code 30468, which requires 20 minutes more total time. In addition, CPT code 30468 is typically performed in the operating room, and CPT code 30469 is typically performed in an office setting. While the intra-service time is the same for both procedures, there is a noticeable difference in intensity between these two services. The RUC noted that the work required for 30468 is less intense and more straightforward, albeit being performed in the operating room and requiring more total time. Though 30469 requires less total time, the intra-service time requires more meticulous care to perform the procedure using the radiofrequency handpiece to determine the appropriate amount of tissue ablation. For this reason, the RUC determined that the survey 25th percentile for code 30469 did not maintain relativity, and a direct crosswalk to CPT code 31295 with 2.70 work RVUs, was more appropriate given the similarities in site of service, total time, and intensity within 20 minutes of intra-service work.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 30140 *Submucous resection inferior turbinate, partial or complete, any method* (work RVU = 3.00, 20 minutes intra-service time and 78 minutes total time) and 31238 *Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage* (work RVU = 2.74, 25 minutes intra-service time and 53 minutes total time) which demonstrate appropriate comparisons to determine relativity. Most of the survey respondents that selected these key reference codes identified the surveyed code as

having either identical or somewhat more intensity and complexity. It is important to note that 30140 is typically performed in the hospital outpatient setting and notably requires more total time. The second key reference service, code 31238, is typically performed in the physician office and has identical total time to the survey code suggesting that the codes should be valued similarly. For additional support, the RUC did a database search of 000-day global codes with intra-service time between 20 and 25 minutes, intensity between 0.08 and 0.12, total time between 40 and 80 minutes, and work RVU between 2.40 and 2.80 and found that the survey code falls appropriately within the middle to upper range of the list. The RUC concluded that the value of CPT code 30469 should be 2.70, which is below the survey 25th percentile and maintains relativity within the family and MFS. **The RUC recommends a work RVU of 2.70 for CPT code 30469.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made modifications to the pre-service clinical staff time to both CPT codes 30468 and 30469 in accordance with current standards. Specifically, the Subcommittee discussed whether the requested inputs were sufficient or whether there was an oversight in valuing the PE for CPT code 30468 previously and whether all time for “extensive use of clinical staff” standards when applied to 000-day global periods, should be included for both codes. The specialty recommended that the standard time for phone calls be included in CA005 *Complete pre-procedure phone calls and prescription*, but not the standard time for CA002 *Coordinate pre-surgery services (including test results)*, as there was not clinical rationale to include it. The PE subcommittee agreed and voted to approve compelling evidence based on a prior error in valuation. Thus, three additional minutes were included for CA005 for both codes in the office and facility settings.

The PE Subcommittee also discussed the new supply and equipment inputs recommended for CPT code 30469. The new supply item, the *VivAer Stylus*, is the radio frequency wand needed to deliver the radio frequency to the nasal valve. It is used for only one patient at a time and disposed of after use. The new equipment item, *Console Set*, is the console required to generate the radiofrequency that is delivered, via the wand, to the nasal valve. The PE Subcommittee noted the high cost of the new supply input and reiterates its previous request to CMS:

The RUC calls on CMS to separately identify and pay for high-cost disposable supplies. The RUC makes this recommendation to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies, but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty. If high cost supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool. **The RUC recommends that CMS separately identify and pay for high-cost disposable supplies priced more than \$500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

Percutaneous Nephrolithotomy (Tab 8)

Kyle Richards, MD (AUA) and Thomas Turk, MD (AUA)

In October 2019, CPT code 50081 was identified via the site of service anomaly screen because it is performed less than 50% of the time in the inpatient setting but includes inpatient hospital E/M services within the global period based on 2016-2018 Medicare claims data. The RUC recommended to survey for the January 2020 RUC meeting. In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without dilation", to describe the work more clearly in current practice. In September 2021, the CPT Editorial Panel revised CPT codes 50080 and 50081 to describe percutaneous nephrostolithotomy by removing "with or without dilation" nomenclature, to differentiate simple and complex services more clearly and to bundle the work of nephrostomy tube placement and image guidance, when performed. In January 2022, CPT codes 50080 and 50081 were surveyed for the RUC meeting. It is important to note that both codes 50080 and 50081 are currently Harvard-valued.

50080 Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in a single location of kidney or renal pelvis, nonbranching stones)

The RUC reviewed the survey results from 276 urologists and recommends a work RVU of 13.50 based on a direct work RVU crosswalk to MPC code 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.50- and 90-minutes intra-service time, 255.5 minutes total time), which maintains relativity within the family and has identical intra-service time and similar intensity and total time. The RUC recommends 36 minutes of pre-service evaluation time, 3 minute positioning time, 10 minutes scrub/dress/wait time, 90 minutes intra-service time, and 40 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 office visits, and 244 minutes total time. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The RUC also noted that CPT Editorial Panel revised this code to newly bundle in the additional work of nephrostomy tube placement and image-guidance, when performed. Under the previous coding structure, these services were separately reported. In addition, the RUC noted that this code was last reviewed as part of the Harvard study, nearly 30 years ago, and this is the first time it is being valued by the RUC. The RUC recommendation accurately accounts for the site of service, decrease in post-service work, and subsequent decrease in total time from the current value and is appropriately lower than the survey 25th percentile given these changes. Additionally, the RUC discussed the time packages and designation as a difficult patient. It was the consensus that the patient is generally considered difficult due to multiple comorbidities (e.g., obesity, chronic kidney disease, hypertension, diabetes, etc.) which increases the complexity and the level of medical decision making. A patient can have a smaller stone but as the stone increases in size, it becomes an emergent issue that requires immediate intervention. There may be a current or developing infection of the renal collecting system due to the stone or surrounding peri-nephric tissues in addition to the increased possibility of infection, including urosepsis, post-procedure due to stone manipulation. Moreover, the intra-service intensity is quite high as the physician is handling the scope the entire time and there is potential to perforate the surrounding arteries and blood vessels. It is also important to differentiate this procedure from a transurethral approach which is typically reserved for less complex cases with smaller stones. As the stone size increases, the complexity increases, and the patient becomes a candidate for this procedure.

For further support, the RUC compared CPT code 50080 to MPC code 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36, 90 minutes intra-service time and 248 minutes total time) and noted that this MPC code appropriately supports the survey code recommendation with identical intra-service time and similar value, total time, intensity, and post-service work. **Therefore, the RUC recommends a work RVU of 13.50 for CPT code 50080.**

50081 Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)

The RUC reviewed the survey results from 277 urologists and recommends a work RVU of 22.00 based on the survey 25th percentile which maintains relativity within the family. The RUC recommends 40 minutes of pre-service evaluation time, 3-minute positioning time, 10 minutes scrub/dress/wait time, 140 minutes intra-service time, and 44 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 office visits, and 302 minutes total time. Survey respondents indicated, and the RUC concurred, that an overnight stay and a same-day post-operative hospital visit are typical.

The RUC also noted that CPT Editorial Panel revised this code to newly bundle in the additional work of nephrostomy tube placement and image-guidance, when performed. Under the previous coding structure, these services were separately reported. In addition, the RUC noted that this code was last reviewed as part of the Harvard study, nearly 30 years ago, and this is the first time being valued by the RUC. Over the years, the physician work to perform this service has evolved and become more efficient, although much more intense given new approaches and technology. Therefore, any comparison to the intensity of the current valuation is unreliable, as the work is significantly different from the Harvard-valuation. Throughout the discussion of the code family, the RUC agreed that this procedure is performed on a difficult patient population. The urologists familiar with performing this procedure would describe a difficult patient as one with multiple comorbidities that have the potential to lead to complications. As discussed in the previous recommendation for CPT code 50080, there is considerable complexity that is added as the size of the stone increases. For this procedure, the patient becomes a candidate when the stone or stone(s) are greater than 2 cm, therefore adding a significant opportunity for possible complications such as infections and/or perforations of surrounding anatomy. The additional intensity and medical decision making far exceeds that of CPT code 50080 as there could be multiple stones in multiple locations and/or branching stones making the removal more anatomically difficult.

For additional support, the RUC compared CPT code 50081 to codes 58573 *Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU = 20.79, 130 minutes intra-service time and 281 minutes total time) and 92987 *Percutaneous balloon valvuloplasty; mitral valve* (work RVU = 23.38, 150 minutes intra-service time and 329 minutes total time) which appropriately bracket the survey code recommendation. The RUC concluded the survey was robust and the 25th percentile appropriately accounts for the physician work required to perform this service. **The RUC recommends a work RVU of 22.00 for CPT code 50081.**

Practice Expense

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

Laparoscopic Simple Prostatectomy (Tab 9)

Kyle Richards, MD (AUA) and Thomas Turk, MD (AUA)

Facilitation Committee #3

In October 2021, the CPT Editorial Panel added CPT code 55867 *Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed*, to describe laparoscopic simple prostatectomy. The family of four codes pertaining to surgical prostatectomy and laparoscopy were surveyed for the January 2022 RUC meeting.

55821 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages

The RUC reviewed the survey results from 144 urologists and recommends a work RVU of 15.18 for CPT code 55821. The specialty society indicated that the survey 25th percentile work RVU of 20.00 overestimated the typical physician work for this procedure and, therefore, recommends a direct crosswalk to 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* (work RVU = 15.18, 120 minutes of intra-service time, and 329 minutes of total time). These services have the same intra-service time, as well as similar total time and intensity of physician work. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232, 1-99238, and 2-99213 post-operative visits. This major surgery, which involves an open approach, is typically performed in the inpatient setting (70% inpatient for 2020 Medicare claims).

For additional support, the RUC referenced MPC codes 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, 120 minutes intra-service time, and 279 minutes total time) which requires slightly less total time than the surveyed code and 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60, 120 minutes of intra-service time, and 313 minutes of total time) which is somewhat more intense to perform. The RUC concluded that these codes accurately bracket the surveyed code and support the recommended work RVU of 15.18. **The RUC recommends a work RVU of 15.18 for CPT code 55821.**

55831 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal

The RUC reviewed the survey results from 139 urologists and recommends a work RVU of 15.60 for CPT code 55831. The specialty society indicated that the survey 25th percentile work RVU of 20.00 overestimated the typical physician work for this procedure, and therefore recommends a direct crosswalk to MPC code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60, 120 minutes of intra-service time, and 313 minutes of total time). These services have the same intra-service time, with similar total time and intensity.

The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99232, 1-99238, and 2-99213 post-operative visits. Differences in operative approach and technique add to the complexity and intensity of the procedure for CPT code 55831. This procedure involves a retropubic approach (behind the pubis) where an incision is made on top of the prostate and the enlarged center portion of the prostate is removed without opening the bladder, which is anatomically more difficult to perform than the suprapubic approach (over the pubis) used in

CPT code 55821. The retropubic approach in CPT code 55831 requires primary ligation of a major complex of blood vessels near the prostate, including the dorsal vascular complex (DVC); the blood vessels are controlled in a more technically difficult manner, and thus an increased work RVU for the retropubic approach is appropriate. This major surgery, which involves an open approach, is typically performed in the inpatient setting (80% inpatient for 2020 Medicare claims).

For additional support, the RUC referenced MPC code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* (work RVU = 15.18, 120 minutes of intra-service time, and 329 minutes of total time) and CPT code 49653 *Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)* (work RVU = 15.68, 120 minutes of intra-service time, and 305 minutes total time). The RUC recognized that these two codes have an identical amount of intra-service time when compared to the surveyed code and appropriately bracket the RVU recommendation of 15.60, further supporting the relativity among similar services in the MFS. **The RUC recommends a work RVU of 15.60 for CPT code 55831.**

55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

The RUC reviewed the survey results from 190 urologists and recommends a work RVU of 22.46 for CPT code 55866. The RUC determined that the survey 25th percentile work RVU of 25.18 somewhat overestimated the typical physician work for this procedure, and therefore, recommends a direct crosswalk to CPT code 35606 *Bypass graft, with other than vein; carotid-subclavian* (work RVU = 22.46, 145 minutes of intra-service time, and 414 minutes of total time). The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes positioning time, 12 minutes scrub/dress/wait time, 180 minutes of intra-service time, 50 minutes of immediate post-service time, 1/2-99238 and 2-99213 post-operative visits. This service is typically provided in the outpatient hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The typical patient for this service is a 48-year-old male diagnosed with prostate cancer who elects robotic-assisted laparoscopic radical prostatectomy. CPT code 55866 requires more time and physician work than CPT codes 55821 and 55831 due to more complex preoperative positioning for a retropubic radical prostatectomy, set-up for laparoscopic robotic assistance, and increased intra-service work related to nerve sparing and urethral reconstruction to prevent long-term complications for cancer patients (such as incontinence and erectile dysfunction). During the procedure, the nonautonomous robotic assistance requires constant surgical input at the hand of the surgeon, which increases technical difficulty. Given the enlarged prostate, it is imperative for the surgeon to carefully spare the surrounding nerves and urethral sphincter muscles when removing the entire prostate and related tissue. Moreover, the significant reconstructive component associated with this service is the reconnection of the bladder neck to the urethra, which needs to be conducted carefully and completely to ensure proper healing and long-term function. Removing the entire prostate with robotic assistance, and the complexity of nerve sparing when operating with a cancerous prostate, increases the medical complexity and intensity of this procedure compared to the other surgical prostatectomy codes in this family.

The RUC compared the surveyed code to CPT code 35304 *Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery* (work RVU = 24.60, intra-service time of 180 minutes, total time of 422 minutes) and noted that both services have an identical amount of intra-service time, whereas the reference code typically involves more total time. The RUC also compared the surveyed code to the second top key reference service 50543 *Laparoscopy, surgical; partial nephrectomy*

(work RVU = 27.41, 240 minutes of intra-service time, and 557 minutes total time) which requires much more physician work and time to perform.

For additional support, the RUC referenced CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU = 22.10, intra-service time of 150 minutes, total time of 404 minutes) and noted that the survey code typically involves 30 more minutes of intra-service time, whereas the reference code involves more total time. The RUC determined that CPT code 55866 is appropriately bracketed by these codes and maintains relativity within the code family and MFS. **The RUC recommends a work RVU of 22.46 for CPT code 55866.**

55867 Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed

The RUC reviewed the survey results from 166 urologists and recommends a work RVU of 19.53 for CPT code 55867. The RUC determined that the survey 25th percentile work RVU of 22.00 was too high compared to the radical laparoscopic prostatectomy, CPT code 55866. The RUC recommends a direct crosswalk to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU = 19.53, 180 minutes of intra-service time, and 383 minutes of total time). The RUC recommends 40 minutes of pre-service evaluation time, 8 minutes positioning time, 11 minutes scrub/dress/wait time, 180 minutes of intra-service time, 50 minutes of immediate post-service time, 1/2-99238 and 2-99213 post-operative visits. This service is typically provided in the outpatient hospital. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The typical patient for this service is a 65-year-old male who is symptomatic due to obstruction enlargement and elects to undergo laparoscopic simple suprapubic prostatectomy. Like CPT code 55866, additional pre-service, intra-service, and post-service time is required for CPT code 55867 when compared to family codes 55821 and 55831. For this procedure, the increased pre-service time is attributable to more complex preoperative work wherein the arms are tucked (identical to CPT codes 55821 and 55831), which requires careful padding to avoid compression injuries or neuropathies); additionally, the legs are placed in stirrups for dorsal lithotomy positioning. More intra-service time, along with a longer postoperative recovery time, is required for the set-up and utilization of laparoscopic robotic assistance. However, when compared to CPT code 55866, the surveyed procedure requires slightly less pre-service time, as it is a simple subtotal laparoscopic prostatectomy as opposed to a retropubic radical approach. The RUC determined that the physician work and time maintain relativity within the surgical prostatectomy code family.

For additional support, the RUC referenced MPC code 55880 *Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance* (work RVU = 17.73, 180 minutes of intra-service time, and 373 minutes total time) and CPT code 60650 *Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal* (work RVU = 20.73, 180 minutes of intra-service time, and 384 minutes of total time). The RUC determined that CPT code 55867 is appropriately bracketed by these codes and maintains relativity within the code family and MFS. **The RUC recommends a work RVU of 19.53 for CPT code 55867.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made minor modifications as presented by the specialty. **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.

Transcutaneous Passive Implant-Temporal Bone (Tab 10)

Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)

In October 2020, the CPT Editorial Panel revised codes 69714 and 69716 to replace “temporal bone” with “skull” and delete “or transcutaneous” and “cochlear stimulator: without mastoidectomy” from the descriptors. The Panel also replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

At the January 2021 RUC meeting, following an initial survey, the RUC reviewed this family of services and determined that they needed to be resurveyed for the April 2021 RUC meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically to include the lower end of the RVU spectrum. The RUC submitted interim recommendations to CMS for CY 2022. The specialty society submitted a letter to the RUC requesting that this code family be referred to the CPT Editorial Panel in May 2021 to clarify the percutaneous implant removal by describing the procedure as removal of the entire implant and adding a parenthetical.

At the April 2021 RUC meeting, the RUC recommended temporarily affirming the January 2021 interim RUC recommendations for work and practice expense inputs for CPT codes 69714, 69716, 69717, 69719, 69726, and 69727 and resurveying these codes for the October 2021 RUC meeting following revisions at the May 2021 CPT Editorial Panel meeting. In May 2021, for CPT 2023, the CPT Editorial Panel established three new codes 69729, 69730, 69728 and added a parenthetical note reporting transcutaneous, passive bone anchored implants for bone conduction hearing appliances. The coding structure was changed to describe the different techniques more appropriately for transcutaneous passive implant procedures that vary in time and intensity depending on the indication for the procedure, device chosen, and patient anatomy. A patient with chronic ear infection and resulting mixed or conductive hearing loss will often require placement of the device outside the mastoid to allow for adequate physical space for the device as well as mitigating infection risk. In these cases, some transcutaneous implants require removal of a significant amount of cranium down to or sometimes beyond the inner cortex in the retrosigmoid area or temporal squama. These cases are technically more difficult, time consuming, and risky. In other cases, such as single-sided deafness, conductive, or mixed hearing loss not resulting from chronic ear inflammatory disease, when the mastoid is well pneumatized, placement of a transcutaneous device in the mastoid is the preferred, less time consuming and less risky location for device placement. Thus, the specialties proposed, and the CPT Editorial Panel had agreed, to make coding changes to bifurcate the transcutaneous codes into placement within the mastoid and/or resulting in removal of less than 100 mm² surface area of cranium beyond its outer cortex versus those that are placed outside of the mastoid and resulting in removal of greater than or equal to 100 mm² surface area of cranium beyond its outer cortex.

The specialty society surveyed the codes for the October 2021 RUC meeting. However, prior to the meeting, it was discovered that one of the survey codes was inadvertently listed on the RSL and was selected as the top Key Reference Service (KRS) code for every code surveyed. After discussion at the October 2021 RUC meeting, the specialty society indicated, and the RUC agreed, that the survey results were invalid and that the codes should be resurveyed for the January 2022 RUC meeting with a revised RSL to be approved by the Research Subcommittee. The Research Subcommittee approved the RSL and a survey was successfully administered for the January 2022 RUC meeting.

Osseointegrated Implant – Description of Family

Within this code family, the least intense services are the removal procedures, the next most intense are the implantation procedures and the most intense are the revision/replacement procedures. To describe the three levels of intensity, the specialty provided the RUC with a detailed explanation about how hearing sensation occurs, what bone anchored hearing aids do to treat patients with certain types of hearing loss and the intensity and risk involved in performing these procedures. Hearing sensation occurs by sound coming into the ear and entering the ear canal; the ear drum vibrates which sends those vibrations to three bones in the middle ear. Those bones increase the vibrations and transmit them to the cochlea, a small snail shaped structure filled with fluid. The fluid in the cochlea moves, activating hair cells, causes stereocilia to bend, which leads to an electrical signal which then is carried by the auditory nerve to the brain, which turns into sound.

When people have hearing loss, it is either conductive hearing loss, which is an issue up to that electric stimulation of the nerve or it is sensory-neural hearing loss, which involves a nerve issue. Hearing loss could also be related to a combination of both conductive and sensory-neural hearing loss. These bone anchored hearing aids treat the conductive portion of hearing loss. Whether it's exclusively conductive or mixed, these devices bypass the external auditory meatus to deliver sound vibrations directly to the inner ear, so it's useful for patients who have conditions such as malformed outer middle ears. For percutaneous bone anchored hearing aids, the patient has a titanium bone implant that is anchored into the skull and is protruding through the skin from the skull. It is then attached to an external microphone and a processor, so these patients have a screw projecting out from their head all the time, through the skin. For transcutaneous bone anchored hearing aids, everything is implanted under the skin within the cranium. That is secured and the skin is closed, and then it eventually attaches to a processor via a magnet which the patient can take on and off, so they do not have anything sticking out through the skin.

Osseointegrated Implant – Implantation

69714 Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor

The RUC reviewed the survey results from 45 physicians and determined the survey 25th percentile work RVU of 8.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 8 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty society noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that the recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the Medicare Physician Payment Schedule (MFS). It was noted that the current CY 2022 CMS times and RVUs in place were based on a flawed survey and interim RUC recommendations from January 2021. The RUC noted that the survey only from one year ago included 10 more minutes of intra-service time and one more post-operative visit.

The RUC noted that the recommended work RVU of 8.00 is almost half that of the 2021 work RVU (14.45). For these procedures, the physician must work with a variety of delicate structures in a very

small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the cerebrospinal fluid (CSF), breaching the intracranial space. All these attributes make these procedures very intense and complex to perform.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively low skin-to-skin times. To justify a work value of 8.00, the RUC compared the surveyed code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45 minutes, total time of 159 minutes) and noted that reference code involves 13 more minutes of total time and supports the proposed value of the survey code. The RUC also compared the surveyed code to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra-service time of 45 minutes, total time of 155 minutes) and noted that the surveyed code involves 9 fewer minutes of total time though is more intense than the reference code. **The RUC recommends a work RVU of 8.00 for CPT code 69714.**

69716 Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 mm2 surface area of bone deep to the outer cranial cortex

The RUC reviewed the survey results from 41 physicians and determined the survey 25th percentile work RVU of 9.03 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 50 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation maintains appropriate relativity both within the family and across the RBRVS.

The implantation procedure described by CPT code 69716 requires more work than CPT code 69714, as it often requires removal of a portion of the cranium. These cases are technically more difficult, time consuming, and risky. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make these procedures very intense and complex to perform.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 9.03, the RUC compared the survey code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159), and noted that the survey code involves more intra-service and total

time, though the reference codes is a slightly more intense service to perform. The RUC also compared the survey code to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra-service time of 45 minutes, total time of 155 minutes) and noted that the survey code involves somewhat more intra-service and total time relative to the reference code and is also a more intense service to perform. **The RUC recommends a work RVU of 9.03 for CPT code 69716.**

69729 Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 mm² surface area of bone deep to the outer cranial cortex

The RUC reviewed the survey results from 40 physicians and determined the survey 25th percentile work RVU of 9.97 appropriately accounts for the physician work required to perform this service. The RUC recommends 29 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 9 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 visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package.

This service requires more work than the other two implantation procedures in the code family as it requires removal of a significant amount of cranium down to, or sometimes beyond, the inner cortex in the retrosigmoid area or temporal squama. These cases are more technically difficult, time consuming, and risky. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make this procedure the most intense and complex to perform when compared to the codes describing implantation of an osseointegrated implant.

To justify a work value of 9.97, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that both services involve an identical amount of intra-service time and a similar amount of total time. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service times and very similar total times, though the survey code is a more intense procedure to perform. **The RUC recommends a work RVU of 9.97 for CPT code 69729.**

Osseointegrated Implant – Revision/Replacement

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 42 physicians and determined the survey 25th percentile work RVU of 8.48 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service

positioning time, 7 minutes of pre-service scrub/dress/wait time, 44 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

The RUC noted that the recommended work RVU of 8.48 is almost half that of the 2021 work RVU (15.43). For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make these procedures very intense and complex to perform. The specialty noted and the RUC agreed that the revision/replacement procedures are the most intense and complex procedures in this code family

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 8.48, the RUC compared the survey code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159) and noted that both services involve a very similar amount of intra-service time and an identical amount of total time, though the reference code is a slightly intense service to perform. The RUC also compared the survey code to CPT code 49013 *Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration* (work RVU= 8.35, intra-service time of 45 minutes, total time of 155 minutes) and noted that both services involve very similar intra-service times), though the survey code involves 4 more minutes of total time. **The RUC recommends a work RVU of 8.48 for CPT code 69717.**

69719 Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 mm² surface area of bone deep to the outer cranial cortex

The RUC reviewed the survey results from 38 physicians and determined the survey 25th percentile work RVU of 9.46 appropriately accounts for the physician work required to perform this service. The RUC recommends 27 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 9 minutes of pre-service scrub/dress/wait time, 55 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation maintains appropriate relativity both within the family and across the RBRVS.

For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make these procedures very intense and complex to perform. The specialty noted and the RUC agreed that the revision/replacement procedures are the most intense and complex procedures in this code family.

To justify a work value of 9.46, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that the survey code involves 5 more minutes of intra-service time and somewhat less total time. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and that although the survey code involves somewhat less intra-service and total time, it is also a more intense procedure to perform. **The RUC recommends a work RVU of 9.46 for CPT code 69719.**

69730 Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm² surface area of bone deep to the outer cranial cortex

The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 10.25 appropriately accounts for the physician work required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 10 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 visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

This service requires more work than the other two revision/replacement procedures in the code family as it requires work outside the mastoid and the added complexity of involvement of a bony defect. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being placed in the cranium at the lateral base of the skull and if the procedure is too deep, then it would mistakenly enter the CSF, breaching the intracranial space. All these attributes make this procedure the most intense and complex to perform within the revision/replacement procedures. The specialty noted, and the RUC agreed, that the revision/replacement procedures are the most intense and complex procedures in this code family.

To justify a work value of 10.25, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that both services involve an identical amount of intra-service time and very similar total time, though the survey code is slightly more intense to perform. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement,*

eyelids, nose, ears and/or lips; defect 10 sq cm or less (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service times, the survey code involves 5 more minutes of total time and is a more intense procedure to perform. **The RUC recommends a work RVU of 10.25 for CPT code 69730.**

Osseointegrated Implant – Removal

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

The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 7.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 35 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being removed from the cranium at the lateral base of the skull. All these attributes make these procedures very intense and complex to perform.

The specialty society asserted that two incorrect assumptions were made for the January 2021 interim value for this procedure: first, that a flawed crosswalk was chosen in the previous valuation of this code, and second, that the January 2021 survey was flawed in that a rank order anomaly existed between the value of 69726 and the other codes in the family. Due to the dearth of potential crosswalks, the RUC chose to crosswalk the interim value for CPT code 69726 to CPT 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 service did have an identical intra time and similar total time; however, surveyed code 69726 is more intense than the code used for crosswalk. In the latest survey for the January 2022 RUC meeting, there was an increase of 5 minute of intra-service time when compared to the January 2021 survey.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 7.50, the RUC compared the surveyed code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159), and noted that reference code involves 10 more minutes of intra-service time and supports the proposed value of the survey code. Within this code family, the least intense services are the removal procedures. **The RUC recommends a work RVU of 7.50 for CPT code 69726.**

69727 Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 mm² surface area of bone deep to the outer cranial cortex

The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 7.38 appropriately accounts for the physician work required to perform this service. The RUC recommends 27 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 50 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted, and the RUC concurred, that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All of this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being removed from the cranium at the lateral base of the skull. All these attributes make these procedures very intense and complex to perform. While still complex, the removal procedures are the least intense services within this code family.

While reviewing reference codes, the RUC noted the dearth of reference codes for 090-day global procedures with relatively lower skin-to-skin times. To justify a work value of 7.38, the RUC compared the survey code to CPT code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU= 9.50, intra-service time of 45, total time of 159), and noted that reference code involves less intra-service and total time, though is a more intense service than the survey code, supporting the survey code's proposed value. The RUC also compared the survey code to CPT code 67911 *Correction of lid retraction* (work RVU= 7.50, intra-service time of 50 minutes, total time of 183 minutes) and noted that both services have identical intra-service times and similar total times. **The RUC recommends a work RVU of 7.38 for CPT code 69727.**

69728 Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm² surface area of bone deep to the outer cranial cortex

The RUC reviewed the survey results from 39 physicians and determined the survey 25th percentile work RVU of 8.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 27 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 8 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 visit (99238) and two post-operative office visits (1x99213 and 1x99212). The specialty noted and the RUC concurred that 10 minutes of positioning time is required to turn the operating room table 180 degrees, which adds complexity and time given all the EKG leads, CO2 sensor, wires and anesthetic tubing that inevitably needs to be properly positioned to complete the turn. The patient's head then needs to be turned and placed in position. Wide tape is used to tape the head to the operating room bed to maintain a fixed position for the duration of surgery. All this requires additional time above the positioning time of standard time package. The RUC noted that their recommendation fully accounts for the large reduction in time relative to the initial valuation of this service and maintains appropriate relativity both within the family and across the RBRVS.

This service requires more work than the other two removal procedures in the code family as it requires work outside the mastoid and the added complexity of involvement of a bony defect. For these procedures, the physician must work with a variety of delicate structures in a very small space just behind the ear. The facial nerve and the large sigmoid sinus blood vessel are both in this area. The bone anchored hearing aid is being removed from the cranium at the lateral base of the skull. All these attributes make this procedure very intense and complex to perform. While still complex, the removal procedures are the least intense services within this code family.

To justify a work value of 8.50, the RUC compared the survey code to CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU= 9.99, intra-service time of 60 minutes, total time of 185.5 minutes) and noted that both services involve an identical amount of intra-service time and similar total time, though the reference code is slightly more intense to perform. The RUC also compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service times and similar total times. **The RUC recommends a work RVU of 8.50 for CPT code 69728.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. The RUC noted that the proposed clinical labor times are based on the standard 090-day global packages. For CA026 *clean surgical instrument package*, which was recommended at 20 minutes, this is twice the standard of 10 minutes because the surgical instrument package is used for both post-operative office visits and the instruments are cleaned after each visit. The PE Subcommittee had confirmed that the two post-operative offices typically require the operating microscope and a set of instruments. The operating microscope is used during each post-operative office visit and is present in the room the entire time during each visit. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

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.

Neuromuscular Ultrasound (Tab 11)

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CPT codes 76881 and 76882 were reviewed as New Technology/New Services by the Relativity Assessment Workgroup (RAW) in January 2015. The RAW recommended that the specialty societies develop a *CPT Assistant* article to define the proper coding of extremity ultrasound, particularly as it applies to the elements necessary to report a complete study and that the RAW should review in October 2016 after additional Medicare utilization data are available. This coding clarification was published in the September 2016 *CPT Assistant*.

In October 2016, the RAW re-reviewed these codes and agreed with the specialty that the dominant specialties providing the complete versus the limited ultrasound of extremity services were different causing variation in the typical practice expense inputs. The RAW recommended to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs for January 2017; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019).

At the January 2017 RUC meeting, the Practice Expense Subcommittee reviewed the direct practice expense inputs for 76881 and 76882 and adjusted the clinical staff time. In June 2017, the CPT Editorial Panel editorially revised ultrasound of extremity codes 76881 and 76882 to clarify the distinction between complete and limited studies and revised the introductory guidelines to clarify reference to one joint in the complete ultrasound procedure.

In October 2019, the RAW reviewed and recommended to again review in two years after additional data are available (January 2022). However, in October 2021, the CPT Editorial Panel approved the addition of code 76883 for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity and the revision of 76882 to add focal evaluation. CPT code 76881 is included as part of this family, therefore, review by the RAW was no longer necessary.

CPT codes 76881 and 76882 were identified as part of the neuromuscular ultrasound code family with CPT code 76883 and surveyed for the January 2022 RUC meeting.

Compelling Evidence

The RUC agreed with the specialty societies that there is compelling evidence to support a change in physician work for the code family based on a documented change in technique and physician time, as supported by the survey. In 2009, CPT code 76880 was deleted, and two new codes were created to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound. When CPT code 76881 was created and surveyed in 2010, radiology was expected to be the dominant provider. This would have typically included initial scanning by a diagnostic medical sonographer and subsequent scanning by a radiologist. When 76882 was created and surveyed in 2010, podiatry was expected to be the dominant provider. This would have typically included scanning performed only by the podiatrist. In 2016, the RUC PE Subcommittee noted that the “dominant specialties providing the complete versus the limited ultrasound of extremity services are different, causing variation in PE” leading to revised PE direct inputs in January 2017. The physician work was not reviewed at that time. In 2022, rheumatology is the top provider for 76881 (25.7% of Medicare claims across all sites) and that specialty did not participate in the original survey. For rheumatology, physicians typically scan the patients with portable ultrasound devices rather than utilizing sonographers as originally described in the 2010 survey. Therefore, the physician work has changed. In 2022, radiology is the dominant physician provider for 76882 (57.3% of Medicare claims across all sites) and typically performs examinations with preliminary ultrasound scanning by a sonographer and additional imaging performed by the physician. Since radiologists do not use portable ultrasound devices as originally described in the 2010 survey or in the 2017 practice expense update, the physician work has changed due to supervision of the sonographer in addition to the radiologist performing the scanning.

In addition, ultrasound technology has evolved immensely since 2010, including proliferation of high-frequency ultrasound probes dedicated to musculoskeletal imaging, as well as producing images with higher fidelity and more detail. This modality is increasingly used for a greater range of musculoskeletal injuries and has replaced MRI as the first line investigation for many pathologies. Furthermore, ultrasound can also be used to troubleshoot difficult cases that are inconclusive on either clinical evaluation or other imaging modalities which supports a change in overall physician time and work. **The RUC concurred that there is compelling evidence that the physician work for these services has changed due to change in physician time and technique/technology.**

76881 *Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation*

The RUC reviewed the survey results from 88 physicians and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the work involved in this service. CPT code 76881 represents a complete evaluation of a specific joint in an extremity. This service requires ultrasound examination of all the following joint elements: joint space (e.g., effusion), peri-articular soft-tissue structures that surround the joint (i.e., muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. Code 76881 also requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (e.g., absent secondary to surgery or trauma). The RUC recommends 5 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of post-service time as supported by the survey. The RUC discussed the change in intra-service time and determined that the increase relates to the compelling evidence argument, as previously there was 15 minutes of intra-service time for the radiologist to scan and/or review the sonographer-obtained images. Whereas now, the rheumatologist is performing the scanning and it typically takes 20 minutes in the current patient population. The RUC noted that this code is reported with an office Evaluation and Management (E/M) visit 58.9% and a non-facility office E/M visit 66.3%; however, the code is imaging-specific so the physician work described would not overlap with the E/M service.

The RUC compared CPT code 76881 to the top key reference service MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81, 11 minutes intra-service time and 21 minutes total time) which is a clinically similar ultrasound code and noted that the reference code has identical pre and post-service time but less intra-service time than the surveyed code. The RUC noted that 76881 has 9 minutes more intra-service and total time than the reference code, which appropriately reflects the evaluation of multiple surrounding structures in addition to the joint, and therefore is appropriately valued higher. In addition, for the reference code, the physician is typically supervising a sonographer and performing additional scanning, as needed instead of directly performing the entire image acquisition portion of the ultrasound study. The RUC also compared the surveyed code to the second highest key reference service MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 47 minutes total time) and noted that the surveyed code has far less physician time than the reference code and therefore is appropriately valued lower.

For additional support, the RUC compared CPT code 76881 to MPC code 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (e.g., high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.90, 15 minutes intra-service time and 22 minutes total time) and noted that the comparator code has less intra-service and total time compared to the surveyed code but is more intense. MPC code 74246 involves examination of a much larger anatomic area compared to the typical anatomic area examined for the surveyed code. The RUC concluded that CPT code 76881 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.90 for CPT code 76881.**

76882 *Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation*

The RUC reviewed the survey results from 100 physicians and determined that the survey 25th percentile work RVU of 0.69 appropriately accounts for the work involved in this service. CPT code 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). This evaluation includes assessment of a specific anatomic structure(s) (e.g., joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all the elements included in CPT code 76881, although it does include all surrounding anatomy and any associated pathology or contralateral comparison as indicated. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated. The CPT Editorial Panel revised the CPT descriptor for this service in October 2021 to include focal evaluation of a nerve. The RUC recommends 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time as supported by the survey. The RUC discussed the change in intra-service time given that this limited code is performed with a sonographer and determined that the increase relates to the compelling evidence argument, as previously there was 11 minutes of intra-service time, whereas now the radiologist is working with the sonographer to obtain and interpret the images in addition to the physician performing additional scanning as needed. Therefore, it takes 15 minutes. The change in physician time is also due to the enhancement of the ultrasound technology whereby the number and quality of images that can be reviewed and the pathology to evaluate have greatly increased since 2010.

The RUC compared CPT code 76882 to the top key reference service code 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* (work RVU = 0.59, 8 minutes intra-service time and 18 minutes total time) which is a clinically similar ultrasound code and noted that the reference code has identical pre and post-service time but less intra-service time than the surveyed code. The RUC noted that CPT code 76882 has 7 minutes more intra-service and total time than the reference code, which appropriately reflects that the limited ultrasound examination of a musculoskeletal structure typically involves evaluation of more adjacent structures and tissues compared to the limited abdominal examination of a single structure, and therefore is appropriately valued higher. The RUC also compared the surveyed code to the second highest key reference service MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 30 minutes total time) and noted that the surveyed code has less intra-service and total time than the reference code and therefore is appropriately valued lower.

For additional support, the RUC compared CPT code 76882 to 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 noted that the codes have identical intra-service time and a similar amount and type of physician work including analysis, interpretation and report of clinical data. The RUC concluded that CPT code 76882 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.69 for CPT code 76882.**

76883 Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity

The RUC reviewed the survey results from 66 physicians and determined that the survey 25th percentile work RVU of 1.21 appropriately accounts for the work involved in this service. CPT code 76883 is for reporting real-time, complete neuromuscular ultrasound of nerves and accompanying structures throughout their anatomic course, per extremity. This code will examine a nerve throughout its length, within one extremity, including evaluation of multiple areas for potential nerve compression, measurement of cross-sectional areas, evaluation of echogenicity, vascularity, mobility including dynamic maneuvers when indicated, evaluation for any associated muscular denervation, with comparison to unaffected muscles or nerves within that extremity as needed. CPT code 76883 also requires permanently recorded images and cine loop and a written report containing a description of each of the elements evaluated. The RUC recommends 7 minutes of pre-service time, 25 minutes of intra-service time and 7 minutes of post-service time as supported by the survey. The RUC clarified that this service would not typically be reported with an office E/M visit.

The RUC compared CPT code 76883 to the second highest key reference service MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54, 29 minutes intra-service time and 49 minutes total time) and noted that the surveyed code has less intra-service and total time than the reference code and therefore is appropriately valued lower. For additional support, the RUC compared CPT code 76883 to MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20, 20 minutes intra-service time and 50 minutes total time) and noted that the comparator code has less intra-service time and lower intensity than the surveyed code and an almost identical amount of physician work. The RUC concluded that CPT code 76883 should be valued at the 25th percentile work RVU as supported by the survey. Moreover, the RUC noted that consistency of intensity measures is demonstrated across the range of codes ascending from the limited code to this newest, most complex 76883 code and the recommendations maintain relatively both among the neuromuscular ultrasound family as well as the larger family of ultrasound imaging codes. **The RUC recommends a work RVU of 1.21 for CPT code 76883.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made updates to reflect the appropriate specialty providing the service in the global and technical component reporting only in the *non-facility setting*: rheumatology (76881), podiatry (76882), and neurology (76883). For the physician work component for CPT code 76882, the radiologist is the dominant provider for physician work at all sites of service; however, for the non-facility global and technical component utilization which determines the top specialty for non-facility practice expense inputs, Podiatry is the dominant specialty. Thus, the radiology inputs were removed from the PE for code 76882 because podiatry is dominant, and there is no sonographer or ultrasound room included in the PE spreadsheet as the physician performs the image acquisition with a portable ultrasound machine instead. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Service

The RUC recommends that CPT code 76883 be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Cognitive Behavioral Therapy Monitoring (Tab 12)
Ronald Burd, MD (APA) and Stephen Gillaspay (APA)

In October 2020, the CPT Editorial Panel created five new CPT codes (98975, 98976, 98977, 98980, 98981) to report remote therapeutic monitoring (RTM) services. Remote therapeutic monitoring treatment management services are provided when a physician or a licensed qualified health care professional (QHP), and/or clinical staff use the results of remote therapeutic monitoring to manage a patient under a specific treatment plan. This family of RTM codes was established to monitor services (e.g., musculoskeletal system status, respiratory system status, therapy adherence, and therapy response) that represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. The RUC reviewed these five services at the January 2021 meeting, and CMS implemented the services for the 2022 Medicare Physician Payment Schedule.

In October 2021, the CPT Editorial Panel replaced Category III codes 0702T *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days* and 0703T *Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; management services by physician or other qualified health care professional, per calendar month* with Category I code 98978 *Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, cognitive behavioral therapy, therapy adherence, therapy response); initial set-up and patient education on use of equipment; device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days*. The CPT Editorial Panel created 98978 for 2023. Codes 0702T and 0703T have been deleted.

98978 Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days

CPT code 98978 is a practice expense only code. The specialty societies indicated that the technology for this service is still evolving. The RUC agreed that due to its emerging and varying technology, CPT code 98978 should be contactor priced to accommodate the wide variability in supplies, equipment and conditions monitored. **The RUC recommends that CPT code 98978 be contractor priced.**

Affirmation of RUC Recommendations

The RUC reviewed the specialty societies' request to affirm the RUC valuations for the recently reviewed CPT codes 98975, 98976, 98977, 98980 and 98981. In October 2021, the CPT Editorial Panel revised the code descriptors for 98975, 98976 and 98977 to include "cognitive behavioral therapy" and created 98978 to report this service. The RUC confirmed that this editorial revision would not change the typical patient most commonly receiving these procedures, which would continue to be patients requiring respiratory and musculoskeletal monitoring. The RUC agreed with the specialty societies that the changes to 98975, 98976, and 98977 are editorial only and do not result in a change in work or the typical patient most commonly receiving these procedures. Additionally, AMA Staff have noted a point of confusion in regard to the "eg" parenthetical in the parent code 98975 as it impacts all subsequent codes (i.e., 98976, 98977, and 98978). Any potential change is editorial and does not require a change in work but would provide clarity for reporting purposes. These codes are part of the additional items for review from the September 2021 CPT Panel meeting at the February 2022 CPT Panel meeting.

The RUC recommends affirming the following recent RUC recommendations:

- 0.00 for CPT code 98975 (PE only)**
- 0.00 for CPT code 98976 (PE only)**
- 0.00 for CPT code 98977 (PE only)**
- 0.62 for CPT code 98980**
- 0.61 for CPT code 98981**

Practice Expense

The PE Subcommittee reviewed the practice expense recommendations for this code and affirmed the inputs from the January 2021 RUC meeting. However, the spreadsheet required minor editorial updates to the CPT descriptors to represent the 2023 CPT approved coding changes. The PE Subcommittee agreed with the request to contractor price CPT code 98978 and requested that the RUC place this service on the New Technology list to be re-reviewed in three years to ensure correct valuation and utilization assumptions.

The RUC requested that those that provide CPT code 98977 provide a paid invoice for the *Remote musculoskeletal therapy system* “device” cost. For 2022, CMS cross-walked this cost to the equipment cost for EQ392 *heart failure patient physiologic monitoring equip*, resulting in a Medicare national payment of \$56 per month. However, the RUC understands that the monthly rental cost is estimated to be \$25 per month and the CMS crosswalk is not based on the actual resource cost. The RUC notes that this problem is mirrored with CPT code 98976, where CMS used a crosswalk not based on resource cost as a proxy for the device equipment, rather than the invoice provided that illustrated the \$25 per month rental cost. CMS should use the actual device cost to determine valuation for each of these codes.

New Technology/New Service

The RUC recommends that CPT codes 98975, 98976, 98977, 98980, and 98981 stay on the New Technology list and recommends that 98978 will be added to the list.

Inpatient and Observation Care Services (Tab 13)

Charles Hamori, MD (ACP), Len Lichtenfeld, MD (ACP), Guy Qrango, MD (ASCRS), Michael Perskin, MD (AGS), Don Selzer, MD (ACS), Korinne Van Keuren, DNP (ANA), Richard Wright, MD (ACC), Robert Zipper, MD (SHM) and Ron Greeno, MD (SHM)

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

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

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making (MDM). Most of the utilization for each service is expected to be inpatient and not observation.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore the survey respondents may not have captured the correct total time on the date of encounter. The specialty societies revised their survey instrument by working with the Research Subcommittee. The RUC reviewed the inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2022 RUC meeting.

COMPELLING EVIDENCE

The specialty societies presented three points for compelling evidence that the work of providing inpatient hospital and observation care visits for the evaluation and management of patients may have changed. First, a change in the patient population, the distillation down to sicker patients who are in the hospital for a shorter period; second, a change in technology due to the widespread implementation of institutional electronic health records (EHR), which are data intensive and therefore more intense for the patient encounters; and third, a change in the providers of these services with the recent emergence of hospitalists and intensivists.

Change in Patient Population

The number of diagnoses that appear in the Medicare claims for inpatient visits (based on the 5% Medicare claims file) has increased in the last 16 years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006, the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%. Physicians are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a skilled nursing facility.

Data from the Chronic Conditions Data Warehouse also support the assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%), and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Technology

EHRs have significantly changed since 2006. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags in the EHR are frequent, as they are put in place for safety reasons, however, these flags require

the physician/QHP rather than clinical staff to review and override any modifications to treatment, such as a medication change, before the clinical staff can continue with care of the patient. The American Hospital Association reported that in 2017¹ 95% of hospitals had some form of EHR implemented. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Change in Provider

Hospitalists are a new and growing specialty that were not fully organized as a specialty in 2006 when the codes were last surveyed. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital² and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.³ In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.⁴ New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.⁵ As the field grows, the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the typical model of outpatient primary care (e.g., rounding in the hospital on their patients) in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.⁶ Shift-based coverage makes at least one handoff between physicians during a 24-hour period, a ubiquitous practice. About 50% of hospitalist groups use a daytime admit model or a hybrid for admissions,⁷ meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult, but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all the hospital visit E/M

¹ SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief No. 46 April 2019

² Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. *N Engl J Med.* 1996;335(7):514-517.

³ Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. *Medicare Medicaid Res Rev.* 2014;4(2):E1-E8.

⁴ Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. *J. Hosp. Med* 2016;1:45-47. doi:10.1002/jhm.2480

⁵ Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data shows an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.

⁶ Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

⁷ Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.⁸

The RUC acknowledges that the existing Medicare data attributes a much smaller proportion of claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) using a Medicare specialty billing code (C6) that was just recently established in 2017. The Medicare claims data greatly underrepresent the proportion of hospitalists who perform these services. Given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today.

The RUC agrees that there is compelling evidence based on a change in patient population, change in technology, and change in the provider of these services.

SURVEY PROCESS AND DATA ANALYSIS

The customized survey, vignettes and reference service lists (RSL) were developed and approved by the Research Subcommittee in conjunction with the CPT/RUC Workgroup on E/M and input from medical specialties. The RSLs were specifically developed in an objective manner to represent relativity within the Medicare Physician Payment Schedule (MFS). The Research Subcommittee considered requests from the surveying specialties to add or remove codes from the initial lists originally developed by the Workgroup. The vignettes were developed by the CPT/RUC Workgroup on E/M and approved by the CPT Editorial Panel and the RUC's Research Subcommittee. Approximately 90 percent of respondents agreed that the vignettes described their typical patient.

The survey was the concerted effort of 24 specialty societies and other health care professional organizations. The RUC analyzed the responses and noted that the number of survey responses received per specialty correlated with those who perform inpatient hospital and observation care visits in the MFS. These data were summarized by categories of specialties (hospital, surgical, primary care and medicine/other). The number of respondents by category were also representative of Medicare allowed charges for inpatient hospital and observation care visits for those same categories.

To ensure that survey respondents understood the new CPT guidelines and descriptors and the impact that these changes may have on their work, the RUC asked that each respondent carefully read the new descriptors/guidelines and attest that they had read the information. The survey respondents understood that code selection will be based on either MDM or time on the date of the patient encounter. While the history and physical is no longer required for purposes of documentation, it is expected that a clinically appropriate history and physical exam is performed during the visit.

For the initial and subsequent hospital inpatient or observation care codes (CPT codes 99221-99233) all time is on the date of encounter, thus intra-service time only. The survey instrument was revised to specify that "unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the "unit/floor". The survey asked about the different components of time to ensure that the respondents considered all appropriate time for these services before floor time, floor time and after floor time. The respondents then needed to confirm that the summed time of the components was the accurate total

⁸ Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

time on the date of encounter for each service to proceed with the survey. Additional details on the survey tool questions and responses are provided in the letter from the specialty societies.

The hospital inpatient or observation services with admission and discharge on the same date (CPT codes 99234-99236) and the discharge management services (99238 and 99239) include **post-service time** because these services include discharge activities where there is contact with the patient and/or family member or further work after the patient had left the hospital. Post-service activities do not occur in the initial or subsequent hospital inpatient or observation care codes because these will be captured when discharged, using CPT codes 99238 and 99239. CPT codes 99234-99236 are based upon total time on the date of encounter if selecting a code level based upon time. The discharge management services are time-based codes only; 30 minutes or less or more than 30 minutes.

INITIAL HOSPITAL INPATIENT OR OBSERVATION CARE

99221 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

The RUC reviewed the survey results from 230 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.63, which is lower than the current work RVU, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) and determined that both services require similar medical decision making, intensity/complexity, time and physician work to perform. Additionally, of the survey respondents who chose 99203 as the key reference service, 64% indicated that CPT code 99221 is somewhat more to much more intense. Thus, the work RVU of 1.63 is appropriate.

For additional support, the RUC referenced MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92 and 47 minutes total time) and determined that 99221 requires a lower level of medical decision making, is slightly less intense/complex and requires less physician time and work to perform. Therefore, supports a lower work RVU for 99221 compared to CPT code 99204.

The RUC also referenced CPT code 99395 *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years* (work RVU = 1.75 and 45 minutes total time), which requires similar physician time and work to perform as CPT code 99221. **The RUC recommends a work RVU of 1.63 for CPT code 99221.**

99222 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

The RUC reviewed the survey results from 250 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.60 appropriately accounts for the work required to perform this service. The RUC recommends 55 minutes of intra-service/total time.

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

The RUC also compared the surveyed code to the second top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes of total time) and determined that CPT code 99222 is appropriately valued lower as it requires a lower level of medical decision making and less physician time. **The RUC recommends a work RVU of 2.60 for CPT code 99222.**

99223 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

The RUC reviewed the survey results from 257 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 74 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that both services require the same level of medical decision making and the same physician work. The RUC noted that of the survey respondents who chose 99205 as the key reference service, 82% indicated that CPT code 99223 is somewhat more to much more intense.

The RUC compared the surveyed code to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.* (work RVU = 4.50 and 70 minutes of total time) and determined that 99223 is less intense, thus valued lower than CPT code 99291.

For additional support the RUC referenced CPT code 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)*

(work RVU = 3.86 and 75 minutes total time). **The RUC recommends a work RVU of 3.50 for CPT code 99223.**

SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE

99231 *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.*

The RUC reviewed the survey results from 234 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes of intra-service/total time, an increase from the current time.

The RUC compared the surveyed code to the top key reference services 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes of total time)

and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU = 0.70 and 16 minutes of total time) and determined that the medical decision making, intensity/complexity, physician time and physician work for 99231 are appropriately bracketed by these two services.

For additional support, the RUC referenced MPC code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.* (work RVU = 0.93 and 20 minutes of total time), which requires only straightforward medical decision making for a new patient and slightly less physician work and time to perform than 99231. **The RUC recommends a work RVU of 1.00 for CPT code 99231.**

99232 *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.*

The RUC reviewed the survey results from 252 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.59 appropriately accounts for the work required to perform this service. The RUC recommends 36 minutes of intra-service/total time.

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

time) and determined that 99232 is slightly more intense/complex but requires less physician time and work to perform. Additionally, of the survey respondents who chose 99214 as the key reference

service, 64% indicated that CPT code 99232 is somewhat more to much more intense. Therefore, supports a lower work RVU for 99232 compared to CPT code 99214.

The RUC compared the surveyed code to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes of total time) and determined CPT code 99232 requires a higher level of medical decision making, is slightly more intense and complex and requires more physician time and work to perform. Additionally, of the survey respondents who chose 99213 as the key reference service, 62% indicated that CPT code 99232 is somewhat more to much more intense.

The RUC noted that the recommended work RVU for 99232 maintains the appropriate relativity with the initial inpatient hospital visit with straightforward or low MDM recommendation 99221 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded* (recommended work RVU = 1.63 and 40 minutes intra-service time).

For additional support, the RUC referenced MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time), which requires similar physician work and time to perform. **The RUC recommends a work RVU of 1.59 for CPT code 99232.**

99233 *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.*

The RUC reviewed the survey results from 258 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC recommends 52 minutes of intra-service/total time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU = 2.80 and 70 minutes total time) and determined that CPT code 99233 requires the same level of medical decision making but less physician time and work to perform. Additionally, of the survey respondents who chose 99215 as the key reference service, 76% indicated that CPT code 99233 is somewhat more to much more intense.

The RUC also compared the surveyed code to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that CPT code 99233 requires a higher level of medical decision making, is more intense/complex, and requires more physician time and

work to perform. Additionally, of the survey respondents who chose 99214 as the key reference service, 81% indicated that CPT code 99233 is somewhat more to much more intense. **The RUC recommends a work RVU of 2.40 for CPT code 99233.**

ADMISSION AND DISCHARGE ON THE SAME DATE

99234 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.-When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

The RUC reviewed the survey results from 58 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.00 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes of intra-service and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that CPT code 99234 has a lower level of medical decision making, is slightly less intense and requires less physician work and time to perform.

The RUC also compared the surveyed code to the second top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60 and 35 minutes total time) and determined that CPT code 99234 requires more physician work and time to perform. Additionally, of the survey respondents who chose 99203 as the key reference service, 71% indicated that CPT code 99234 is somewhat more to much more intense. **The RUC recommends a work RVU of 2.00 for CPT code 99234.**

99235 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate of medical decision making.-When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.

The RUC reviewed the survey results from 59 physicians and other qualified healthcare professionals and determined that the current work RVU of 3.24 appropriately accounts for the work required to perform this service. The RUC recommends 68 minutes of intra-service and 8 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that CPT code 99235 requires a lower level of medical decision making, and less physician work and time to perform. However, of the survey respondents who chose 99205 as the key reference service, 71% indicated that CPT code 99235 is somewhat more to much more intense.

The RUC also compared the surveyed code to the second top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that CPT code 99235 requires more physician work and time to perform. Given the higher intensity of the hospital care and the added work of discharge, the RUC agreed that the current value of 3.24 places 99235 in proper rank order to the key reference services. Additionally, of the survey respondents who chose 99204 as the key reference service, 84% indicated that CPT code 99235 is somewhat more to much more intense. **The RUC recommends a work RVU of 3.24 for CPT code 99235.**

99236 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making.-When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.

The RUC reviewed the survey results from 59 physicians and other qualified healthcare professionals and determined that the survey median work RVU of 4.30 appropriately accounts for the work required to perform this service. The RUC recommends 85 minutes of intra-service and 12 minutes post-service time. The RUC noted that the total time has increased slightly, since this survey captured total time on the date of encounter, which is all indicated in the intra-service time. The RUC noted this was a reallocation of time but not necessarily an increase of 30 minutes intra-service time from what it was previously.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that although both codes require the same level of medical decision making, CPT code 99236 is more intense and complex and requires more physician time and work to perform. Additionally, of the survey respondents who chose 99205 as the key reference service, 85% indicated that CPT code 99236 is somewhat more to much more intense.

The RUC also compared the surveyed code to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.* (work RVU = 4.50 and 70 minutes total time) and determined that although CPT code 99236 requires more time to perform, it is much less intense. **The RUC recommends a work RVU of 4.30 for CPT code 99236.**

DISCHARGE DAY MANAGEMENT

99238 Hospital inpatient or observation discharge day management; 30 minutes or less

The RUC reviewed the survey results from 167 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 28 minutes of intra-service and 10 minutes post-service time.

The RUC compared the surveyed code to the top key reference services 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes total time) and 99214 *Office or other outpatient visit for the evaluation*

and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. (work RVU = 1.92 and 47 minutes total time) and determined that since 99238 is a time-based code that it is appropriately valued higher than 99213 since it requires more physician time and work and is appropriately valued lower than 99214 since it requires less physician time and work. Additionally, of the survey respondents who chose 99213 as the key reference service, 75% indicated that CPT code 99238 is somewhat more to much more intense and for those who chose 99214 as the second top key reference service, 69% indicated that CPT code 99238 is somewhat more to much more intense.

For additional support, the RUC referenced MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter (work RVU = 1.60 and 35 minutes total time) since it requires similar physician work and time to perform. **The RUC recommends a work RVU of 1.50 for CPT code 99238.***

99239 Hospital inpatient or observation discharge day management; more than 30 minutes

The RUC reviewed the survey results from 171 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 2.15 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes of intra-service and 19 minutes post-service time.

The RUC compared the surveyed code to the top key reference services 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (work RVU = 2.80 and 70 minutes total time) and 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. (work RVU = 1.92 and 47 minutes total time) and determined that since 99239 is a time-based code that it is appropriately valued higher than 99214 since it requires more physician time and work and is appropriately valued lower than 99215 since it requires less physician time and work. Additionally, of the survey respondents who chose 99215 as the key reference service, 76% indicated that CPT code 99238 is somewhat more to much more intense.*

For additional support, the RUC referenced MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist (work RVU = 2.50 and 36.5 minutes intra-service time, 66.5 minutes total time). **The RUC recommends a work RVU of 2.15 for CPT code 99239.***

CPT DESCRIPTOR TIME

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

CPT Code	Descriptor	Time on the Date of Encounter Rec to CPT
99221	Initial hospital inpatient or observation care per day, straightforward or low MDM	40
99222	Initial hospital inpatient or observation care per day, moderate MDM	55
99223	Initial hospital inpatient or observation care per day, high MDM	75
99231	Subsequent hospital inpatient or observation care per day, straightforward or low MDM	25
99232	Subsequent hospital inpatient or observation care per day, moderate MDM	35
99233	Subsequent hospital inpatient or observation care per day, high MDM	50
99234	Hospital inpatient or observation care, admission and discharge on the same date, straightforward or low MDM	45
99235	Hospital inpatient or observation care, admission and discharge on the same date, moderate MDM	70
99236	Hospital inpatient or observation care, admission and discharge on the same date, high MDM	85

PRACTICE EXPENSE

The Practice Expense (PE) Subcommittee affirmed the PE recommendations for CPT codes 99238 and 99239 as approved without modification in October 2021. The other inpatient and observation care codes are facility-only and have no direct PE inputs. The only direct practice expense inputs are for CA036 *Discharge Day Management*, with 12 minutes for CPT code 99238 and 15 minutes for CPT code 99239. The RUC noted that the discharge services have always included and continue to include these clinical activities. Time is allocated for office clinical staff to perform coordination of care activities during a hospitalization including phone calls that office based clinical staff have with family members who have clinical questions regarding care about a hospitalized patient and phone calls with hospital clinical staff to exchange clinical data between the office and the hospital. These could be calls initiated by the hospital staff or by the office staff. These activities are in support of hospitalized patients and are necessary to provide patient care. In addition to time for clinical staff work during a hospitalization, there are clinical staff activities associated with discharge day management services. Typically, there will be discharge management related calls to the patient/family/pharmacy/other providers. This work has not changed. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

GLOBAL SURGICAL PERIOD

The RUC recommends that the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239) be incorporated into the surgical global periods for each CPT code with a global of 010-day, 090-day, MMM (maternity) codes and other codes that have hospital visits included in the valuation. The RUC recommends that the practice expense inputs should be modified for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239) within the global periods. The RUC agrees that inpatient hospital and observation care work is equivalent and a crosswalk of 100% of the inpatient hospital and observation care visit valuations should be bundled into the codes with global periods of 010-days, 090-days, MMM and other codes that have hospital visits included in the valuation. A spreadsheet itemizing these changes is included in the attached supporting material.

Inpatient Consultations (Tab 14)

Phillip Rodgers (AAHPM), Guy Orangio, MD (ASCRS), Don Selzer, MD (ACS) and Richard Wright, MD (ACC)

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

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

In February 2021, the CPT Editorial Panel deleted two consultation codes and revised eight consultation codes to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient consultation, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing the patient are summed to select the appropriate code. The inpatient consultation services were initially surveyed for the October 2021 RUC meeting. The inpatient consultation survey time captured the total time on the date of encounter by calendar date. In October 2021, the RUC referred the inpatient and observation consultation services to be resurveyed, because the survey did not include a request for distinct fields for time before and after floor/unit time, and therefore could not be compared to previous RUC surveys of these services. The specialty societies revised their survey instrument by working with the Research Subcommittee. The RUC completed its review of the office or other outpatient consultation codes (99242-99245) at the October 2021 meeting and submitted recommendations for 99242-99245 to CMS only for those services.

Although the recommended work RVUs for codes 99252-99255 are not greater than the current values, the specialty societies noted, and the RUC agreed, that the compelling evidence of a change in the patient population and a change in technology that supported the increased work RVUs for the inpatient visit codes (99221-99239) also provides support for an increase in intensity of work for inpatient consultation codes. Specifically, that there has been a change in the patient population as Medicare patients have increasing rates of comorbidities that in turn increase the complexity and intensity of work. In addition to high prevalence of diabetes, hypertension, and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%), and rheumatoid arthritis/osteoarthritis (29% to 35%). There has also been a change in technology. The establishment of EHRs since these codes were last reviewed has dramatically changed care, allowing for more information requiring review and analysis. Patients present at a hospital with acute problems or exacerbation of current problems. Assessment of the problem needs to be performed expeditiously. The increased knowledge base in EHRs has increased intensity and complexity of patient care by requiring review and analysis of

more data in the same or shorter amount of time. The American Hospital Association reported that in 2017, 95% of hospitals had some form of EHR implemented. This is a significant change from 2006. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Since the inception of the Medicare Physician Payment Schedule, the work RVUs for the inpatient consultation codes have always been valued higher than the inpatient visit E/M codes; the Harvard study acknowledged a relative difference in work in 1991 and the RUC confirmed a relative difference in work in 2006.

SURVEY PROCESS AND DATA ANALYSIS

The customized survey, vignettes, and reference service lists (RSL) were developed and approved by the Research Subcommittee in conjunction with the CPT/RUC Workgroup on E/M and input from the surveying specialties. The RSLs were specifically developed in an objective manner to represent relativity within the Medicare Physician Payment Schedule. The Research Subcommittee considered requests from the surveying specialties to add or remove codes from the initial lists originally developed by the Workgroup. The vignettes were developed by the CPT/RUC Workgroup on E/M and approved by the CPT Editorial Panel and the RUC's Research Subcommittee. Approximately 90% of respondents agreed that the vignettes described their typical patient.

The survey was the concerted effort of 25 specialty societies and other health care professional organizations. The RUC analyzed the responses and noted that the number of survey responses received per specialty correlated with those who perform inpatient consultation care visits in the Medicare Physician Payment Schedule, based on 2009 utilization data (when these services were last covered by Medicare). These data were summarized by categories of specialties (hospital, surgical, primary care, and medicine/other).

To ensure that survey respondents understood the new CPT guidelines and descriptors and the impact that these changes may have on their work, the RUC survey instrument required that each respondent carefully read the new descriptors/guidelines and attest that they had read the information before being allowed to proceed with the survey. The survey respondents understood that code selection could be based on either MDM or time on the date of the patient encounter. While the history and physical is no longer required for purposes of documentation, it is expected that a medically appropriate history and physical exam is performed during the visit.

For the inpatient or observation consultation codes (CPT codes 99252-99255) all time is on the date of encounter, thus intra-service time only for the purposes of . The survey instrument was revised to specify that "unit/floor time" is no longer the basis of time when selecting a code level based upon time. It is total time on the date of the encounter, whether on or off the "unit/floor". The survey asked about the different components of time to ensure that the respondents considered all appropriate time for these services before floor time, floor time and after floor time. The respondents then needed to confirm that the summed time of the components was the accurate total time on the date of encounter for each service to proceed with the survey. Additional details on the survey tool questions and responses are provided in the letter from the specialty societies.

99252 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

The RUC reviewed the survey results from 206 physicians and other qualified health care professionals (QHPs) and determined the survey median work RVU of 1.50 appropriately accounts for the physician and other QHP work required to perform this service. The RUC recommends 35 minutes total time. The RUC noted that CPT code 99251 has been deleted and some or all its previous utilization will now be reported with CPT code 99252. The 2009 Medicare utilization of CPT code 99251 was only 27% of the Medicare utilization for 99252, thus the typical patient for a 99252 will not change.

The specialties noted, and the RUC concurred, that inpatient and observation consultation codes should be valued somewhat higher than the analogous inpatient or observation new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. However, it was noted that the revised descriptor for CPT code 99221 (RUC recommended work RVU = 1.63, 40 minutes total time) is for straightforward or low medical decision making, whereas inpatient consultation code 99252 is only for a straightforward level of medical decision making, justifying a somewhat lower valuation for 99252 relative to 99221. The report prepared by the consultation physician would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests to be performed.

To justify a work RVU of 1.50, the RUC compared the surveyed code to the top key reference service and MPC code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 20 minutes total time) and determined that CPT code 99252 typically requires substantially more physician work and 15 more minutes of total time, thus would be valued appropriately higher with a work value of 1.50. The RUC compared the surveyed code to the 2nd key reference service and MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 35 minutes total time) and noted that although both services involve an identical amount of total time, the surveyed code involves a lower level of medical decision making relative to the reference code (straightforward vs. low), and therefore maintains relativity with this reference service. **The RUC recommends a work RVU of 1.50 for CPT code 99252.**

99253 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

The RUC reviewed the survey results from 219 physicians and other QHPs and determined the survey median work RVU of 2.00 appropriately accounts for the physician and other QHP work required to perform this service. The RUC recommends 45 minutes total time.

The specialties noted, and the RUC concurred, that inpatient and observation consultation codes should be valued somewhat higher than the analogous inpatient or observation new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. However, it was noted that the revised descriptor for CPT code 99221 (RUC recommended work RVU = 1.63, 40 minutes total time) is for straightforward or low medical decision making, whereas inpatient consultation code 99253 is only for a low level of medical decision making, justifying a higher valuation for 99253 relative to 99221. The report prepared by the consultation physician would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests to be performed.

To justify a work RVU of 2.00, the RUC compared the surveyed code to the top key reference service and MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 35 minutes total time) and determined that CPT code 99253 typically requires more physician work and time, thus would be valued appropriately higher with a work value of 2.00. The RUC also compared the surveyed code to MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU= 1.92, total time of 47 minutes) and noted that the reference code typically involves 2 more minutes of total time and is for a moderate level of medical decision making. However, the surveyed code is for both new and established patients, is in the inpatient setting, and is a consultation, which collectively is more work than the level of medical decision making and minor time differentials when compared with 99214. In addition, the RUC compared the surveyed code to MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 35 minutes total time) as additional support of the recommended value. **The RUC recommends a work RVU of 2.00 for CPT code 99253.**

99254 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

The RUC reviewed the survey results from 234 physicians and other QHPs and determined the survey 25th percentile work RVU of 2.72 appropriately accounts for the physician and other QHP work required to perform this service. The RUC recommends 60 minutes total time.

To justify a work RVU of 2.72, the RUC compared the surveyed code to top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes) and concurred that, even though both services have identical total time, code 99254 should be valued with a slightly higher work RVU relative to 99204 to account for the increased intensity and complexity of the hospitalized patient. The RUC referenced that 78% of the survey respondents that selected this top key reference service had indicated that 99254 is more intense/complex. The RUC also compared the surveyed code to 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU= 2.80, total time of 70 minutes) and noted that the reference code typically involves 10 more minutes of total time and is for a high level of medical decision making. However, the surveyed code is for both new and established patients, is in the inpatient setting and is a consultation, which combined nearly offset the level of medical decision making and time differentials. **The RUC recommends a work RVU of 2.72 for CPT code 99254.**

99255 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.

The RUC reviewed the survey results from 223 physicians and other QHPs and determined that the survey median work RVU somewhat overestimated and the survey 25th percentile underestimated the physician and QHP work typically required to perform this service. , The RUC agreed that a value between the survey 25th percentile and survey median would most appropriately account for the physician and other QHP work required to perform this service. The RUC recommends a direct work RVU crosswalk to CPT code 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)* (work RVU= 3.86, total time of 75 minutes), agreeing that although the reference code involves slightly more total time, both services involve a comparable amount of physician work. The RUC recommends 80 minutes total time.

In support of the crosswalk value, the RUC also compared the surveyed code to top key reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU= 3.50, total time of 88 minutes) and concurred that 99255 should be valued higher based on a slightly higher intensity relative to 99205 and referenced that 83% of the survey respondents that selected this top key reference service had indicated that 99255 is more intense/complex. The specialties noted, and the RUC concurred, that inpatient consultation codes should be valued somewhat higher than the office or other outpatient new patient visit with the same level of medical decision making to account for the more acute work in the inpatient setting and the work of generating and sending a written report to the requesting physician. The report provides recommendations for the management of the patient and identify additional labs, imaging and/or tests to perform. The specialties also noted that a consultation typically involves a greater amount of data to review at the high-level decision-making level relative to new patient office visit code 99205. **The RUC recommends a work RVU of 3.86 for CPT code 99255.**

CPT Descriptor Time for Inpatient Consultations

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

CPT Code		Time on the Date of Encounter Recommendation to CPT
99252	Inpatient or Observation Consultation, new or est pt, straightforward MDM	35
99253	Inpatient or Observation Consultation, new or est pt, low MDM	45
99254	Inpatient or Observation Consultation, new or est pt, moderate MDM	60
99255	Inpatient or Observation Consultation, new or est pt, high MDM	80

Practice Expense

The RUC recommends no direct practice expense inputs for CPT codes 99252-99255 as they are facility-only services.

Work Neutrality

Based on the 2009 Medicare utilization data from when these services were last covered by Medicare, the RUC's recommendation for this family of codes would result in an overall work savings.

Prolonged Services-on the Date of an E/M (Tab 15)

Megan Adamson, MD (ACS), Audrey Chun, MD (AGS), Brad Fox, MD (AAFP), Charles Hamori, MD (ACP), Steven Krug, MD (AAP), Len Lichtenfeld, MD (ACP), Elisabeth Volpert, DNP (ANA) and Meghan Ward, MD (AAN)

In February 2021, the CPT Editorial Panel created prolonged inpatient service add-on code 99418 to report prolonged face-to-face and non-face-to-face total time provided by the physician or other qualified health care professional (QHP) on the date of an inpatient service (ie, 99223, 99233, 99236, 99255, 99306, 99310). The Panel also revised CPT code 99417, so it would also be used to report prolonged office consultations, home and domiciliary visits and cognitive assessment and care plan services (in conjunction with 99245, 99345, 99350, 99483) in addition to prolonged office and other outpatient visits (with conjunction with codes 99205 and 99215). Codes 99417 and 99418 are only to be reported when the primary service has been selected using time alone as the basis for code level selection and only after the time required to report the highest-level service has been exceeded by 15 minutes. The Panel also deleted the *Prolonged Service with Direct Patient Contact (Except with Office or Other Outpatient Services)* subsection including codes 99354-99357.

In October 2021, the specialty societies surveyed the two prolonged service on the date of an E/M codes (99417, 99418) but did not obtain the required number of survey responses for code 99418. The specialty noted, and the RUC concurred, that the January 2022 meeting is still within the current cycle and would not delay recommendations pertinent to the 2023 Medicare Physician Payment Schedule.

Compelling Evidence for 99418

The specialty societies presented three points for compelling evidence that the work of providing inpatient hospital and observation care visits for the evaluation and management of patients may have changed, including for prolonged inpatient add-on code 99418, which is part of the same code family. First, a change in the patient population, the distillation down to sicker patients who are in the hospital for a shorter period; second, a change in technology due to the widespread implementation of institutional electronic health records (EHR), which are data intensive and therefore more intense for the patient encounters; and third, a change in the providers of these services with the recent emergence of hospitalists and intensivists.

Change in Patient Population

The number of diagnoses that appear in the Medicare claims for inpatient visits (based on the 5% Medicare claims file) has increased in the last 16 years since these codes were last reviewed. The largest changes are occurring at the higher-level services. Since 2006, the number of diagnoses has increased by more than 30% for all the codes except 99221 and 99222 which have gone up 25%. For example, for 99223 the number has increased by 31% and for 99233, the increase is 41%. Physicians are experiencing more complicated patients, with more clinical indications to review and consider, while balancing moving these more complicated patients to the next setting of care, such as a skilled nursing facility.

Data from the Chronic Conditions Data Warehouse also support the assertion that Medicare patients have increasing rates of comorbidities that in turn increase the complexity of hospitalizations. In addition to high prevalence of diabetes, hypertension, and COPD among Medicare beneficiaries, there has been marked increase between 2010 and 2019 in rates of chronic kidney disease (15% to 26%), depression (14% to 19%), and rheumatoid arthritis/osteoarthritis (29% to 35%).

Change in Technology

EHRs have significantly changed since 2006. Some of the most obvious differences are requirements for pharmacy potential interactions to be overridden by the physician, as necessary. Additionally, flags in the EHR are frequent, as they are put in place for safety reasons. However, these flags require the physician/QHP rather than clinical staff to review and override any modifications to treatment, such as a medication change, before the clinical staff can continue with care of the patient. The American Hospital Association reported that in 2017⁹ 95% of hospitals had some form of EHR implemented. As reported in 2006 by the Healthcare Financial Management Association, only 13% of hospitals had an EHR for health outcomes; 13% for clinical decision support; and 2% for patient access.

Change in Provider

Hospitalists are a new and growing specialty that was not fully organized as a specialty in 2006 when the codes were last surveyed. The term "hospitalist" was coined in 1996 to describe a trend of primary care physicians choosing to practice exclusively in the hospital¹⁰ and the field began to organize in earnest in the early 2000s. Hospitalists are predominantly internal medicine trained, but there are also a significant number of hospitalists with the specialties of family medicine, pediatrics, and medical subspecialties. In 2011, there were 25,787 adult hospitalists identified using a 90% threshold of Medicare billing claims associated with hospitalizations.¹¹ In 2012, there were 28,473 hospitalists identified using a nearly identical 90% threshold.¹² New analyses using the same data and methodology suggest the field has continued to grow at a similar rate through 2019, with approximately 44,000 hospitalists identified.¹³ As the field grows, the model and systems of care associated with hospitalists continues to spread. In 2006, the impact of hospitalists on the care of hospitalized patients would not have been as pronounced as it is today.

Hospitalist practice diverges from the typical model of inpatient primary care (e.g., rounding in the hospital on their patients) in several important ways. First, hospitalists provide 24-hour coverage of patients in the hospital using a shift-based model. Shifts are typically 12 (~64% of groups) or 10 (~20% of groups) hours long.¹⁴ Shift-based coverage makes at least one handoff between physicians during a 24-hour period, a ubiquitous practice. About 50% of hospitalist groups use a daytime

⁹ SOURCE: ONC/American Hospital Association (AHA), AHA Annual Survey Information Technology Supplement: 2015-2017.

Note: The sample consists of 3,599 non-federal acute care hospitals. "There was a 7 percent increase between 2015 and 2016 in the percent of hospitals that use their EHR data." ONC Data Brief No. 46 April 2019

¹⁰ Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. *N Engl J Med.* 1996;335(7):514-517.

¹¹ Welch WP, Stearns SC, Cuellar AE, Bindman AB. Use of hospitalists by Medicare beneficiaries: a national picture. *Medicare Medicaid Res Rev.* 2014;4(2):E1-E8.

¹² Lapps J, Flansbaum B, Leykum L, Boswell J, Haines L, Identification of Hospitalists. *J. Hosp. Med* 2016;1:45-47. doi:10.1002/jhm.2480

¹³ Unpublished analysis by the Society of Hospital Medicine on Medicare Provider Utilization and Payment data show an average +2,200 increase in number of hospitalists identified year over year from 2012-2019. SHM is planning to seek publication of this data.

¹⁴ Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

admitter model or a hybrid for admissions,¹⁵ meaning patients who enter the hospital overnight are admitted by one clinician and then dedicated staff the following morning continue the care. These handoffs make assessments of time spent with the patient on a calendar day difficult but reflect the reality of team-based care in many hospitals.

Finally, using 90% threshold-identified hospitalists to examine trends in Medicare billing data shows that, in 2019, hospitalists are billing the plurality of charges for nearly all the hospital visit E/M codes. For example, in 2019, hospitalists accounted for 10.2% of 99221, 15.1% of 99222 and 31.9% of 99223 of the total volume of Medicare bills for each of these codes.¹⁶

The RUC acknowledges that the existing Medicare data attributes a much smaller proportion of claims to hospitalists as this includes only the small proportion of hospitalists who voluntarily identified in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) using a recently established Medicare specialty billing code (C6), therefore underrepresenting the proportion of hospitalists who perform these services. Given the demonstrated growth in the number of hospitalists, the 2006 valuations reflected a provider mix that is no longer representative of the healthcare system today.

The RUC agrees that there is compelling evidence based on a change in patient population, change in technology, and change in the provider of these services.

99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management services)

The RUC reviewed survey responses from 98 physicians and other qualified healthcare professionals and determined that a work RVU of 0.61 appropriately accounts for the physician work required to perform this service. This is the survey 25th percentile and current work RVU (for both 99417 and G2212). The RUC recommends 15 minutes of total time. It is important to note that this service may only be reported with CPT codes 99205, 99215, 99245, 99345, 99350 and 99483 and may not be reported for any time less than 15 minutes. The RUC noted that even though the CPT Editorial Panel revised the coding structure so 99417 will now also be reported with prolonged office consultations, home and domiciliary visits, and cognitive assessment and care plan services, most of the visits are expected to still be reported with the office visit codes 99205 and 99215. Even with the CPT parenthetical change, 99417 is expected to be reported a large majority of the time with office visits.

To justify a work RVU of 0.61, the RUC compared the surveyed code to top key reference code 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; 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)* (work RVU= 0.70, total time of 20 minutes) and noted that although the reference code typically involves 5 more minutes of total time, the physician or QHP work described by the survey code of providing direct patient care for an office or other outpatient services for typically complex patient is more intense than time spent supervising clinical staff for a

¹⁵ Society of Hospital Medicine. 2020 State of Hospital Medicine Report. Published August 2020.

¹⁶ Unpublished analysis by the Society of Hospital Medicine on publicly available Medicare Provider Utilization and Payment Data.

chronic care management service. Therefore, the RUC concurred with the specialties that the surveyed code is a more intense service to perform and should be assigned a work value somewhat lower than the reference code.

The RUC also compared the surveyed code to another office or other outpatient service, MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU= 0.70, total time of 16 minutes), and concurred with the specialties that a work RVU of 0.61 placed 99417 in proper rank order to 99212, an XXX-global code with a similar amount of total time. The RUC noted that a recommendation of 0.61 work RVUs and 15 minutes of total time would assign the surveyed code 99417 an intensity that is identical to the volume-weighted intensity assigned to office visit codes 99202-99215, the code family with which 99417 will most commonly be reported. The RUC also noted that 81% of the survey respondents concurred that the typical patient would either have a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function. The RUC concluded that the value of CPT code 99417 should be maintained at 0.61 work RVUs as supported by the survey 25th percentile. **The RUC recommends a work RVU of 0.61 with 15 minutes total time for CPT code 99417.**

99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management services)

The RUC reviewed survey responses from 124 physicians and other qualified healthcare professionals and determined that the survey 25th percentile work RVU of 0.81 appropriately accounts for the physician work required to perform this service. The RUC recommends 20 minutes of total time. The RUC noted that this service may only be reported with CPT codes 99223, 99233, 99236, 99255, 99306, 99310 and may not be reported for any time less than 15 minutes.

To justify a work RVU of 0.81, the RUC compared the surveyed code to top key reference code 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; 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)* (work RVU= 0.70, total time of 20 minutes) and noted that although both add-on E/M services require the same amount of total time, however, the physician or QHP work of providing direct patient care for an inpatient or observation visit is more intense than time spent supervising clinical staff for a chronic care management service. The RUC also compared the surveyed code to second key reference and MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU= 2.25, total time of 30 minutes) and noted that the surveyed code, with 10 less minutes of total time and somewhat less intensity, maintains the appropriate relativity to this reference service. The RUC also noted that 86% of the survey respondents concurred that the typical patient would either have a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function. **The RUC recommends a work RVU of 0.81 with 20 minutes total time for CPT code 99418.**

Practice Expense

At the October 2021 RUC meeting, the Practice Expense Subcommittee reviewed the direct practice expenses and made modifications to remove all direct practice expense inputs from CPT code 99418 since it is a facility-only code. The equipment input ED021 *Computer, desktop, w-monitor* was removed from CPT code 99417 on the basis that this is an indirect expense. Consistent with the current inputs for G2212 and the RUC's prior recommendations for 99417, equipment inputs EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *exam table* were included in the recommended inputs for code 99417 in the non-facility setting. Since it is an add-on to a face-to-face evaluation and management service in the outpatient (i.e., non-facility) setting and the patient will typically be occupying an exam room during the prolonged service. At the January 2022 meeting, the Practice Expense Subcommittee affirmed its previous recommendations from the October 2021 meeting. The Practice Expense Subcommittee had confirmed that the prolonged service would typically occur with the patient still in the room, and therefore, the otoscope-ophthalmoscope and the exam table would be present in the room the entire time during the typical prolonged service visit. The Practice Expense Subcommittee discussed how these codes are being used and requested that CPT code 99417 be reviewed by the RAW once claims data becomes available so that the RUC can learn whether it is being billed as solitary units or in multiples and confirm the typical scenario in which this code is reported. Even with the CPT parenthetical change, 99417 is expected to be reported a large majority of the time with office visits. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Recommendation to Delete HCPCS code G2212

Currently (for CY 2022), the Centers for Medicare & Medicaid Services (CMS) assigns CPT code 99417 a Medicare Status of "I" *Not valid for Medicare purposes*. In lieu of 99417, Medicare uses another code for reporting prolonged office or outpatient services, G2212 *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report g2212 for any time unit less than 15 minutes)*, though that code is redundant with the newly revised 99417, which has also been revised to be reported with prolonged office consultations, home and domiciliary visits and cognitive assessment and care plan services (99245, 99345, 99350, 99483) in addition to being reported with prolonged office or outpatient visit services (99205, 99215). **The RUC recommends for CMS to delete HCPCS code G2212.**

Relativity Assessment Workgroup Review

The RUC recommends that CPT code 99417 be re-reviewed by the RAW once Medicare claims data is available to learn whether it is being reported as solitary units or in multiples and confirm the typical scenario in which this code is reported. Even with the CPT parenthetical change, 99417 is expected to be reported a large majority of the time with office visits.

X. CMS Request/Relativity Assessment Identified Codes

Delayed Creation of Exit Site from Embedded Catheter (Tab 16)

Charles Mabry, MD (ACS)

In the Final Rule for 2022, CMS requested practice expense (PE) information for the non-facility/office setting for CPT code 49436 upon public nomination that this code can be safely performed in the non-facility/office but is not priced in this setting. CMS agreed that CPT code 49436

can be safely performed in the non-facility/office. Further, valuing the code in the non-facility could ease the burden to the provider and the patient when trying to coordinate access to ambulatory surgical center (ASC) restricted schedules during the continued severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease 2019 [COVID-19]) public health emergency (PHE). CMS finalized CPT code 49436 as potentially misvalued and indicated it is appropriate to explore establishing a practice expense relative value in the non-facility/office setting. Therefore, the RUC reviewed the PE inputs for this low volume service at its January 2022 meeting.

The PE Subcommittee agreed with the specialty society that there is compelling evidence to support an increase in the direct PE inputs based on a change in site-of-service to the non-facility/office setting.

The PE Subcommittee reviewed the practice expense recommendations for this code and approved the inputs with no modifications. Several new supply items were identified, and invoices have been obtained and submitted. The clinical staff type was questioned, and ultimately supported as L051A RN, not a blend, for CA011 *Provide education/obtain consent* and CA018 *Assist physician or other qualified healthcare professional-directly related to physician work time (100%)*. According to the specialty society, a significant amount of education will be provided about the procedure and care of the externalized catheter and pending dialysis by a registered nurse who is familiar with peritoneal dialysis. A surgeon who would perform this procedure in the office setting will have a registered nurse as clinical staff available for this education. Further, the clinical staff for this surgical procedure will typically be a registered nurse who is familiar with peritoneal dialysis catheter care and who will assist 100% of the time (incision, irrigation, heparin flush, connection supplies, dressings). All of the other clinical activities would not require a nurse so they have instead been assigned the L037D RN/LPN/MTA blend staff type.

The PE Subcommittee requested clarification whether it is typical to perform a 99212 post-operative office visit within the global period for 49436. The specialty noted that this visit is typical for suture removal, to ensure the site does not get infected and is typically performed by the physician who performed the procedure. The clinical staff assist the surgeon during the post-operative office visit for a wound and catheter check. **The RUC recommends the direct practice expense inputs as submitted by the specialty society for CPT code 49436.**

Relativity Assessment Workgroup Review

The RUC recommends that the Relativity Assessment Workgroup review CPT code 49436 when three years of claims data are available to assess if there is a shift in the specialty performing these services.

Lumbar Laminotomy with Decompression (Tab 17)

Hussein Elkousy, MD (AAOS), John Ratliff, MD (AANS), Clemens Schirmer, MD (CNS) and Karin Swartz, MD (NASS)

In October 2018, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar*, in which the Medicare data from 2014-2017 indicated that it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period. The Relativity Assessment Workgroup requested an action plan for January 2019. In January 2019, the RUC recommended that this code be reviewed in two years (January 2021) to determine if the CPT 2017 changes to differentiate percutaneous, endoscopic, and open spine

procedures were effective to for correct reporting of this service. In December 2020, the Workgroup noted that CPT code 63030 continues to be primarily reported in the outpatient setting yet still includes inpatient hospital visits. The specialty society indicated that there is still confusion, and 63030 is inappropriately being reported in the outpatient setting. The RUC recommended that CPT code 63030 be referred to the CPT Editorial Panel to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The RUC understood that this service would be surveyed after the CPT revisions and reviewed by the RUC. At the September 2021 CPT meeting, the CPT Editorial Panel did not accept the changes to the descriptors specifying hospitalization as presented by the specialty societies. Since this is a site of service issue, CPT code 63030 was surveyed with the code family for the January 2022 RUC meeting.

Compelling Evidence

The RUC agreed with the specialty societies that flawed methodology was used in the previous valuation of this service. CPT code 63035 is a Harvard-based code and the methodology that Harvard used in developing the work and times was flawed. The Harvard study method for reviewing "secondary codes" (ie, add-on codes) was to survey the primary code as a global code and the add-on code as a multiple of the primary code and then subtract one from the other to determine the additional work related to the secondary code.¹⁷ For example, the data for CPT code 63030 surveyed as a 090-day global code was compared with the data for CPT code 63035 surveyed as a 090-day global code for two levels. The Harvard study used two different panels of neurosurgeons to survey each code resulting in data that did not make sense; some elements of work were lower for 63035 even though a hemilaminectomy of two levels was performed. Further, the difference in total time between the two surveys was 51 minutes, but the final Harvard dataset indicated 49 minutes of intra-service time for 63035. The specialty societies indicated that this was a flawed methodology to determine both the physician time and relative value for 63035, resulting in an underestimation of time and work required, which meets compelling evidence. Secondly, the Harvard study solicited responses only from neurosurgeons (n=17) even though an almost equal number of orthopaedic surgeons perform this service. **The RUC agreed there was compelling evidence that the previous methodology establishing the value for CPT code 63035 was flawed.**

63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

The RUC reviewed the survey results from 79 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 15.95 appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation, 20 minutes positioning, 15 minutes scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99214 and 2-99213 visits. This service is typically performed in the hospital inpatient setting. The RUC noted that the current physician time for CPT code 63020 was not determined via a typical RUC survey but was based on operative logs and Harvard data which was validated during the 1995 Five-Year Review.

The specialty societies indicated that the first post-operative office visit will typically be level 99214 and includes a discussion with the patient of the preop presentation, review of the operative note and comparison of subjective and objective preop versus postop elements of function. Dressings will be removed. The wound will be assessed and sutures removed. The surgeon will verify the pathology report is consistent with disc material and no other concerning pathology and reassure the patient with that information. Medication management is performed including a prescription drug monitoring

¹⁷ Appendix D4.1 of the Harvard Phase III Final Report

program (PDMP) check and to verify use as appropriate with postop instructions and no adverse events. The surgeon will also discuss safely weaning the patient from narcotics and muscle relaxants and discussing how the medication use might impact the patient's ability to work, drive, study, and provide childcare safely. The surgeon will further discuss appropriate use of NSAIDs (prescribed or over the counter (OTC)) and/or other analgesics to switch to as the patient is transitioned from narcotics and muscle relaxants. Orders for changes in medication will be made based on the patient's response to pain experience and medication adverse events. The surgeon will discuss activity guidance, advancing activities, and potential medication-impact on activity. The surgeon will review activity levels and discuss physical and occupation therapy needs and goals, including order therapy. The surgeon will also assess the need for bracing (eg, for foot droop). Shared decision making and assessment of the patient will be required to determine if further imaging or testing is needed, including whether an X-ray should be ordered if there are concerns for iatrogenic instability; whether an MRI should be ordered if there are concerns for incomplete decompression or recurrent herniation of the nucleus pulposus (HNP); and whether a urinalysis and/or post-void residual is needed if there are concerns for urologic dysfunction. Functional needs are assessed that may require coordination with physical medicine and rehabilitation for a debilitated patient. In addition, return to work/school forms will be completed, including guidance on advancing activities toward full return to work/school after review of the patient's view of their work needs in context of their human resource (HR) specified work needs.

The second and third post-operative office visits will typically be level 99213 and include interval update of medical history, physical examination, medication management, PT/OT progress review, order revision, interval imaging as needed, and continued assessment of patient progress watching for recurrent HNP.

The RUC compared the surveyed code to the top key reference service 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) and noted that both require similar physician work and the same intra-service time, however 63047 has an appropriately slightly lower work RVU to account for the difference in physician work intensity between lumbar and cervical spine surgery. The RUC noted that 72% of the survey respondents that selected the top key reference code had indicated that the survey code is more intense and complex. The RUC compared the surveyed code to the second top key reference service 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time and 355 minutes total time). Although codes 63075 and 63020 are both cervical spine operations, code 63075 has a higher work RVU compared with 63020 to appropriately account for the added intensity and complexity of an anterior cervical approach to the spine that includes dissection and protection of the trachea, esophagus and vessels including the carotid.

For additional support, the RUC referenced MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.75, 103 minutes intra-service time and 337 minutes total time). **The RUC recommends a work RVU of 15.95 for CPT code 63020.**

63030 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

The RUC reviewed the survey results from 90 neurosurgeons, orthopaedic surgeons, and spine surgeons and determined that the current work RVU of 13.18, which is below the survey 25th work

RVU, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes pre-service evaluation, 15 minutes positioning, 15 minutes scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238, 1-99214 and 2-99213 visits. The RUC noted that the current pre-service time was established prior to the establishment of pre-time packages and the intra-service and immediate post-service time has not changed.

This service is typically performed in the outpatient hospital setting. However, of the 82% of survey respondents who indicated that they typically perform this service in the hospital, 52% indicated that patients stay overnight (40% less than 24 hours and 12% more than 24 hours) and all respondents indicated a hospital visit occurs. Therefore, a total of 40 minutes post-service time includes the survey median time of 30 minutes plus the intra-time of 10 minutes for current code 99231. Additionally, half a 99238 discharge visit is included even though this patient will not typically be discharged on the same day and complete discharge day management work will be performed on the day after surgery.

The first post-operative office visit will typically be level 99214 and includes a discussion with the patient of the preop presentation, review of the operative note, and comparison of subjective and objective preop versus postop elements of function. Dressings will be removed. The wound will be assessed and sutures removed. The surgeon will verify the pathology report is consistent with disc material and no other concerning pathology and reassure the patient with that information. Medication management is performed including a prescription drug monitoring program (PDMP) check and to verify use as appropriate with postop instructions and no adverse events. The surgeon will also discuss safely weaning the patient from narcotics and muscle relaxants and discuss how the medication use might impact the patient's ability to work, drive, study, and provide childcare safely. The surgeon will further discuss appropriate use of NSAIDs (prescribed or OTC) and/or the use of other analgesics as the patient is transitioned from narcotics and muscle relaxants. Orders for changes in medication will be made based on the patient's response to pain experience and medication adverse events. The surgeon will discuss activity guidance, advancing activities, and potential medication-impact on activity. The surgeon will review activity levels and discuss physical and occupation therapy needs and goals. Shared decision making and assessment of the patient will be required to determine if further imaging or testing is needed, including whether an X-ray should be ordered if there are concerns for iatrogenic instability; whether an MRI should be ordered if there are concerns for incomplete decompression or recurrent herniation of the nucleus pulposus (HNP); and whether a urinalysis and/or post-void residual is needed if there are concerns for urologic dysfunction. Functional needs are assessed that may require coordination with pain management and rehabilitation (PM&R) for a debilitated patient. In addition, return to work/school forms will be completed, including guidance on advancing activities toward full return to work/school after review of the patient's view of their work needs in context of their HR specified work needs.

The second and third post-operative office visits will typically be level 99213 and include interval update of medical history, physical examination, medication management, PT/OT progress review, order revision, interval imaging as needed, and continued assessment of patient progress watching for recurrent HNP.

The RUC compared the surveyed code to the top key reference service 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) and noted that although both services typically involve an identical amount of intra-service time and similar intensity, the reference code involves much more total time as it is typically performed in the inpatient setting. The RUC compared the surveyed code to the second top key reference service

22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level* (work RVU = 15.00, 90 minutes intra-service time, and 271 minutes total time) and noted that code 22867 is more intense and complex than code 63030 due to bilateral decompression as well as placement of an interlaminar/interspinous process stabilization/distraction device and therefore is appropriately valued higher even though it has a somewhat lower total time.

For additional support, the RUC referenced MPC codes 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU = 13.16 and 75 minutes intra-service time), 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36 and 90 minutes intra-service time) and 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.50 and 90 minutes intra-service time). The RUC concluded that the value of CPT code 63030 should be maintained at 13.18 work RVUs, below the survey 25th percentile. **The RUC recommends a work RVU of 13.18 for CPT code 63030.**

63035 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)*

The RUC reviewed the survey results from 81 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey median work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes intra-service and total time.

The RUC noted that this service was never surveyed via the RUC process and the current value and time is based on the flawed Harvard methodology as indicated in the compelling evidence.

The RUC compared the surveyed code to the top key reference service 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47 and 45 minutes intra-service time) and noted that the surveyed code requires more physician time and work to perform. CPT code 63048 describes the work of extending a laminectomy to an additional level. In 63048, the skin incision is extended either higher or lower, followed by additional fascial incision and dissection of paraspinal muscles to expose the next level of the spine. Radiographic localization is not necessary since the work is routinely performed at an adjacent level. Hence the exposure in 63048 builds off the exposure used for the base code. For CPT code 63035, especially when using a tubular retractor system, the exposure is completed de novo. A new, unique fascial incision is made remotely from the fascial incision (described by the base code), followed by new dissection of paraspinal musculature and new placement of a retractor. For a tubular retractor, new radiographs are required for docking the retractor safely upon the lamina and ensuring appropriate retractor position. The exposure of CPT code 63035 is unique and does not directly build off the exposure of the base code and therefore requires more time and work when compared to CPT code 63048.

The RUC compared the surveyed code to the second top key reference service 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy 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 of intra-service time) and noted that the surveyed service requires less physician work and is less intense.

For additional support, the RUC referenced 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 CPT code 63621 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)* (work RVU = 4.00 and 60 minutes intra-service time). The RUC concluded CPT code 63035 should have a work RVU of 4.00 which appropriately accounts for the work required to perform this service. **The RUC recommends a work RVU of 4.00 for CPT code 63035.**

Practice Expense

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

XI. Administrative Subcommittee (Tab 18)

Margie Andreae, MD, Chair, summarized the Administrative Subcommittee report to the RUC.

Doctor Andreae indicated that the Subcommittee reviewed and approved the two candidates for the rotating seats. The elections occurred Saturday morning and Doctor Andreae welcomed Donna E. Sweet, MD, to the primary care rotating seat and Adam Weinstein, MD, to the internal medicine rotating seat.

RUC Compelling Evidence Standards

Doctor Andreae indicated that the Subcommittee focused on two issues related to compelling evidence standards.

1) *Flawed methodology* – specifically, whether a CMS revised value would alone be added to the compelling evidence standards as an example of a flawed methodology. The Subcommittee agreed that CMS revised value should not itself be considered a compelling evidence argument. The Subcommittee agreed that regardless of the source of the value, RUC or CMS, if the methodology used to reach the value could be shown to be flawed and examples are provided, then flawed methodology could be used or offered as compelling evidence. Doctor Andreae clarified that just because CMS does not accept a RUC recommended value and lowers the value, perhaps without a clear methodology, that this alone will not be an acceptable flawed methodology.

The Administrative Subcommittee noted that adding too many specifics to what is considered flawed methodology may rubber stamp a standard without detailed RUC review. The Subcommittee agreed that it did not want to make a blanket statement that all CMS lower valued services are flawed, as it does “assume the current value to be correct.” The Subcommittee agreed that currently specialty societies may present compelling evidence that the current value is flawed including services where the RUC recommended value was not accepted by CMS, and they must provide specific data or evidence that incorrect assumptions were made in the previous valuation of the service to support their compelling evidence. **The Administrative Subcommittee recommended maintaining the current compelling evidence standards — all flawed methodology compelling evidence arguments will continue to be reviewed on a case-by-case basis. However, to clarify when the valuation should be taken into consideration, the Administrative Subcommittee recommends editing that compelling evidence on a flawed methodology previous valuation may be provided for previous RUC or CMS valuations. The Administrative Subcommittee recommended the following change to the *RUC Rules Regarding Presentation and Evaluation Compelling Evidence*:**

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- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:
 - a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;
 - a flawed mechanism or methodology used in the previous valuation, **by either the RUC or CMS** for example: evidence that no pediatricians were consulted in assigning pediatric values or CMS/Other source codes; and/or
 - a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

2) Potential Revision to Compelling Evidence

At the October 2021 RUC meeting, under the new business discussion, a RUC member requested that the RUC consider rationale be included for compelling evidence standards that would state, “changes in the delivery of health care, such as the need to manage more complex patient problems in the office and the need to manage the chronic diseases and multiple comorbidities of elderly patients, have had a particularly significant impact on the physician work involved in providing office services to established patients. In addition, post-service work, such as arranging for further studies and communicating further with the patient, family, and other professionals, is a greater proportion of total work than it used to be and greater than what is suggested by the Harvard study.”

The Administrative Subcommittee discussed adding this specific statement and noted it would need to be pared down and specific language would need to be provided on what edits should be made. Some concepts such as a “change in delivery of health care” could potentially be beneficial to add if clarified. **The Subcommittee agreed that the concepts of compelling evidence brought forth in the request are already included under the change in “knowledge/technology” or “patient population” standard in which documentation in peer-reviewed medical literature or other reliable data would be provided to demonstrate that there have been changes in physician work and no edits are necessary at this time.** The Subcommittee noted that the RUC member who made this request can bring forth specific edits during another meeting new business request if they wish to pursue further with the Administrative Subcommittee.

The RUC approved this report as presented. The full Administrative Subcommittee report is attached to these minutes.

XII. Practice Expense Subcommittee (Tab 19)

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

At the October 2021 RUC meeting, the PE Subcommittee determined that a new PE workgroup should be created to determine whether the addition of another pre-service time package is warranted for major surgical procedures. The Pre-Service Clinical Staff Time Package for Major Surgical Procedures Workgroup held its first meeting in December 2021 and reviewed substantial background on this issue from three prior workgroups.

The Workgroup noted that it is taking a fourth review of this issue because the current process, whereby the presenting specialty societies provide rationale for pre-service time higher than the standard on a case-by-case basis, is being challenged as demonstrated in the CY 2022 final rule. Since

there are no defined packages for major surgeries that are 000-day or 010-day, any deviations for additional pre-time seem less likely to be understood and accepted.

The next meeting of the Pre-Service Clinical Staff Time Package for Major Surgical Procedures Workgroup will be held in mid-February 2022. Further information will be provided and discussed including identifying all 000-day and 010-day global codes with 60 minutes of pre-service clinical staff times, and also identifying codes where the RUC recommended 60 minutes of clinical staff pre-time and identifying the time implemented by CMS.

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 20)

John Proctor, MD, Chair, provided the Relativity Assessment Workgroup (RAW) report to the RUC.

Re-review of Services – Review Action Plans

CMS/Other – Utilization over 20,000

Counseling Visit for Lung Cancer (G0296)

In 2019, code G0296 was identified via the CMS/Other – Utilization over 20,000 screen. In October 2019, the Workgroup recommended review of this service again in 2 years (Jan 2022). The Workgroup reviewed this service noting that the utilization is appropriate and there is no evidence of misvaluation. **The Workgroup recommends maintaining code G0296 and removing it from this screen.**

CMS 000-Day Global Typically Reported with an E/M

Gastrostomy Tube Replacement (43762 & 43763)

These services were identified via the CMS 000-Day Global Typically Reported with an E/M screen and reviewed by the RUC in January 2018. At that time the RUC recommended that these codes be reviewed by the Relativity Assessment Workgroup in two years to examine utilization data to determine if 90% of 43760 are directed to 43762 and 10% to 43763, as projected. The RUC indicated that the Workgroup should also examine if these codes are typically reported with E/M services and if the global period assignment should remain 000.

The Workgroup reviewed these services and determined that the utilization split is as was projected. Additionally, these services are not typically reported with office visits, hospital visits or emergency department visits and the 000-day global period assignment is appropriate. The specialty society voiced concern with the utilization by providers that are not expected to perform this surgical procedure. It is possible that, because 2019 was the first year for this new low volume code, that there may be a misunderstanding of this procedure resulting in misreporting. Therefore, the specialty societies indicate they will develop a CPT Assistant article that describes correct reporting of 43763 and contrasts this procedure with 43762 and other codes for g-tube placement (eg, 43246, 49440). **The Workgroup recommends that CPT codes 43762 and 43763 be maintained/removed from this screen and referred to CPT Assistant to describe scenarios when each of these services should be reported.**

CPT Assistant Analysis

Multi-layer Compression System (29584)

CPT code 29584 was initially identified as New Technology/New Services and reviewed at the October 2015 RAW meeting. The Workgroup recommended that the specialty societies develop a

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CPT Assistant article (published in August 2016) to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, the RUC noted that the utilization is low but still growing and determined to re-review in 3 years (January 2022). The Workgroup reviewed CPT code 29584 and agreed with the specialty society that the volume of this service is low and continues to decrease. **The Workgroup recommends that CPT code 29584 be maintained and removed from the CPT Assistant Analysis screen.**

Advance Care Planning (99497 & 99498)

The RUC reviewed these codes in January 2014 and the RUC recommended that codes 99497 and 99498 be referred to CPT Assistant to educate physicians on how to code this service correctly. In October 2017, the RUC recommended that more utilization data be collected and that the Relativity Assessment Workgroup review this service again in 2 years (January 2022). The Workgroup reviewed these services and noted that, although there is a low percentage of the total Medicare population reported for these services, the Medicare utilization of these services exceed well above the original projection. The Workgroup determined that the relationship of these advance care planning services in comparison to the recent changes in evaluation and management services should be examined. **The Workgroup recommends that CPT codes 99497 and 99498 be surveyed for physician work and practice expense for the April 2022 RUC meeting.**

High Volume Growth

Chemical Cauterization of Granulation Tissue (17250)

In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The RUC reviewed this list and recommended that the specialty societies submit an action plan for January 2016 explaining the high volume growth. In January 2016, the Relativity Assessment Workgroup recommended referral of 17250 to CPT for revision of the descriptor or inclusion of a parenthetical regarding appropriately reporting of 17250 in contradistinction to 97597 and 97598. Also, to the Workgroup recommended referral to CPT Assistant to describe when to appropriately report 17250 or 97597 and 97598. The Workgroup determined to review utilization data and providers of this service in October 2019. In September 2016 the CPT Editorial Panel editorially revised this code and added guidelines for reporting chemical cauterization. In October 2019, the Workgroup recommended to review the utilization again in two years (January 2022).

The Workgroup reviewed CPT code 17250 and noted that the dominant Medicare provider is Family Medicine in the nursing facility and skilled nursing facility. The specialty societies indicated that the increase in CPT code 17250 reporting is due to this service's absence from the consolidated billing list of codes for nursing facilities. The specialty societies recommended that the American Academy of Family Physicians (AAFP) publish a membership educational article and that this service be re-reviewed. **The Workgroup recommends that CPT code 17250 be re-reviewed in 3 years (January 2025) following publication of an AAFP membership educational article and additional utilization data is obtained. The Workgroup recommends that the RUC notify CMS that CPT code 17250 should be added to the consolidated billing list of codes for nursing facilities to curb the misreporting for work that is paid to the facility.**

Laser Treatment – Skin (96920, 96921 & 96922)

These services were originally identified in 2008 via the CMS Fastest Growing screen. The Workgroup agreed that 96920, 96921 and 96922 should be re-assessed in two years. In September 2011, the RUC recommended resurvey these services for January 2012 and development of a CPT Assistant article to address the incorrect reporting when using handheld devices. The article was published in June 2012. In April 2015, the RAW reviewed services for which the RUC recommended that a CPT Assistant article be developed. The Workgroup requested that the specialty societies

develop an action plan to address the increase in utilization and effectiveness of the CPT Assistant article. In October 2015, the RUC again recommended that the specialty societies develop a CPT Assistant article to ensure the codes were being used correctly. The May 2013 article was limited to a question of treating a scar using the laser codes 96920-96922, stating that their use would not be appropriate, and that 96999, *Unlisted special dermatological service or procedure*, should be used instead. A comprehensive article, with examples, on the use of the use of the three laser codes is needed. The Workgroup recommended re-review in 2017 following publication and dissemination of the article. The RUC noted that this service was also identified under the high volume growth screen. The RUC determined to review the growth as well in 2017. In October 2017, the specialty societies noted that the CPT Assistant article was published in September 2016 and requested that additional utilization be reviewed. The RUC recommended that the RAW review this service in 2 years (October 2019). In October 2019, the Workgroup recommended re-review of these services in two years (January 2022), since therapy for psoriasis has changed and utilization of these services should continue to decrease.

In January 2022, the Workgroup reviewed these services, noting that they continue to steadily increase, specifically CPT code 96920. The specialty societies indicated that they believe the growth is appropriate due to changes in treatment and medication for psoriasis. **However, due to the continued growth, the Workgroup recommends that CPT codes 96920, 96921 and 96922 be surveyed for work and practice expense at the April 2022 RUC meeting.**

Work Neutrality (CPT 2018)

Home INR Monitoring (93792, 93793 & G0250)

In October 2019, the RUC identified this family as having more than a 10% increase in work RVUs for 2018 than what was projected. The actual increase was 311%. In January 2020, the Workgroup noted CMS created G0250 to describe these services before 93792 and 93793 were developed. The Workgroup noted that 93792 and 93793 were new codes and an increase was expected as these services were not specifically described before. The Workgroup also noted that the RUC recommended that CMS delete G0250 at that time. CMS did not delete these G codes as they describe different tests. The Workgroup recommended reviewing in 2 years and continued to support the specialty societies' recommendation that CMS delete the G code.

In January 2022, the Workgroup reviewed this family of services. The specialty societies indicated that these services were never projected as work neutral. CMS created the G codes to report home INR testing and interpretation when it issued a national coverage determination (NCD) covering home INR services. G0248 is the initial training of home INR with some supplies and equipment and staff time. G0249 is resupply for another month of home INR. G0250 is interpretation/management of one month of home INR, or **four** tests. When these G codes appeared on the RUC high volume growth screen, the societies approached CPT to create CPT codes that capture those three elements, but also capture the broader work of anticoagulation management for any INR test wherever it is obtained. G0248 is basically equal to 93792. CPT did not want to create an equivalent, PE-only re-supply code equivalent to G0249. In the new code construct, G0250 would be the same as **four** individual 93793s. In addition, 93793 could be billed if a patient went to a lab to get an INR test or had one done in the clinician's office, although it is not reportable the same day as an E/M. A revised neutrality calculation in the spreadsheet demonstrates that if source utilization of G0250 is multiplied by 4, as was the original intent of the societies, budget neutrality was within 3% in 2018.

The specialty societies continue to request that CMS delete G0248, G0249 and G0250, however, note that these services will soon become obsolete. Fewer patients have the associated mechanical valves and warfarin use will diminish as a management option.

The Workgroup recommends that CMS delete G0248, G0249 and G0250 and CPT codes 93792 and 93793 be maintained and reviewed by the Relativity Assessment Workgroup in 3 years (January 2025).

Gender Equity Payment

At the AMA/Specialty Society RVS Update Committee's (RUC) request, the American College of Obstetricians and Gynecologists (ACOG) and the American Urological Association (AUA) convened a joint workgroup to review activities highlighting potential disparities in Medicare payment for female procedures compared to their counter male procedures.

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

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

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

Additional Analysis

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

Conclusions

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

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

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

Articles Related to Gender Equity Payment

- Benoit (2017):
 - Premise: Gender-specific procedure reimbursement bias based on 1997 study
 - Methods: Aired 50 procedures that were “anatomically similar”
 - Conclusion: Based on work RVU only, authors concluded bias existed in gender related procedures
 - Critique: No other RUC criteria were evaluated: time, global period and post-op, when/how RUC reviewed, CMS accepted/rejected
- Uppal (2021)
 - Premise: Relook at gender-specific procedures
 - Methods:
 - NSQIP median incision to closure time (excluding <5%, >95) vs. RUC typical intra-time: reported difference as “median over-reported time”
 - Calculated work RVU per hour for multiple surgical specialties (gyn in middle range of RVU/hour)
 - Conclusions:
 - “AMA-RUC uses inaccurate self-reported RUC surveys for operative times”
 - Work value discrepancy for gender-specific procedures in gynecology
 - Critique:
 - NSQIP vs. RUC time: two different measurements; median vs. mode, what is the procedure distribution? bell shaped? multiple peaks, data for times not collected at same time

- Work RVU per hour: inaccurate calculation using median NSQIP time, no other RUC related considerations - global period and post-op, when/how RUC reviewed, CMS accepted/rejected

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

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

The Workgroup noted that the RUC welcomes critique and suggestions for improvement of the RUC process and the RBRVS. In its consideration of the work by the ACOG-AUA joint workgroup on potential disparities in healthcare reimbursement for gender-specific procedures, the Relativity Assessment Workgroup agrees that the principal direction of the studies and editorials referenced focus on non-RBRVS issues or signal a misunderstanding of the payment system. **The Workgroup supports the activity of ACOG and AUA to prepare an article for publication addressing the flawed findings of the referenced articles.**

Informational Items

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

The RUC approved this report as presented. The full Relativity Assessment Workgroup report is attached to these minutes.

XIV. Research Subcommittee Workgroup (Tab 21)

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

Minutes, May 24 Research Subcommittee Specialty Requests Conference Call and Pre-Call/Post-Call Electronic Review

The Research Subcommittee report from the October 19 conference call included in Tab 21 of the January 2022 agenda materials was approved without modification.

Discussion – Using survey data only from the dominant specialty

At the October 2021 RUC meeting, a RUC member requested that the Research Subcommittee review when it is appropriate to utilize survey data from the dominant specialty or health profession that performs the service versus using all survey data. The Research Subcommittee began the discussion by reviewing an example of when the RUC had only used survey data from the dominant specialty, the RUC recommendation for somatic nerve injection code 64400 in October 2018. That recommendation was based on the neurology survey data, as neurology was the top performing specialty (47% of 2017 claims) yet there were fewer survey responses from neurology than from anesthesiology (10% of 2017 claims).

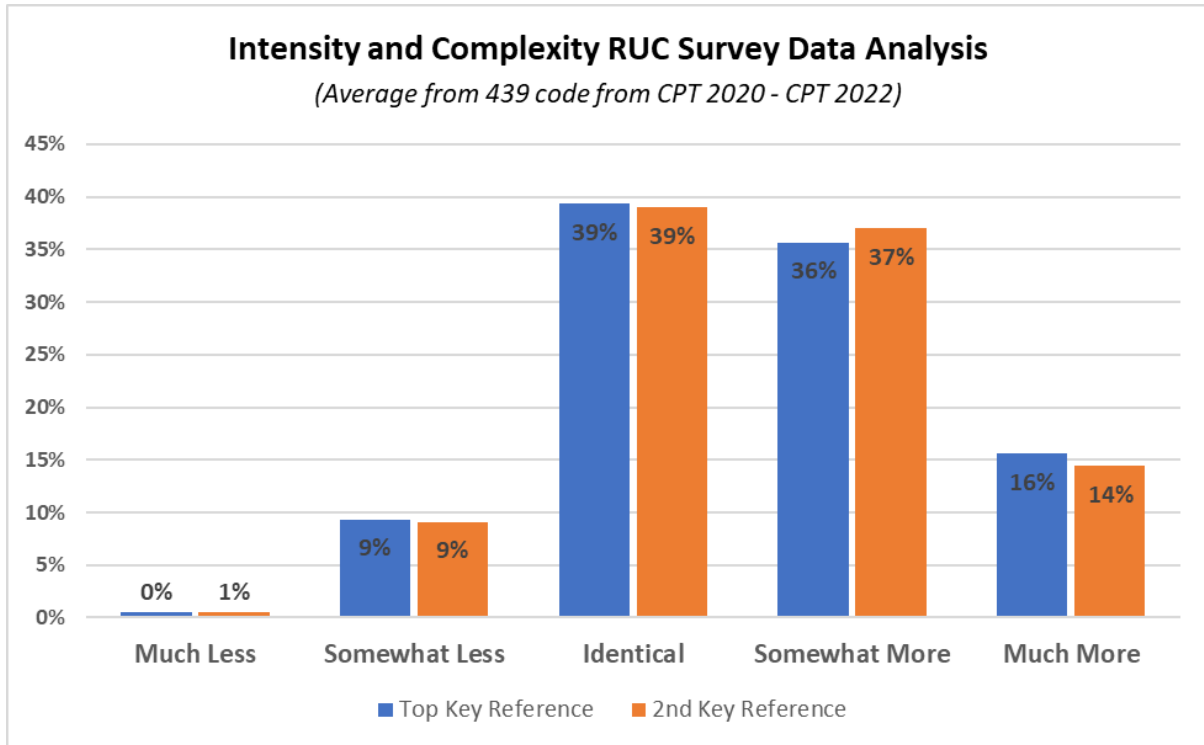
The Subcommittee inquired what is currently done to reduce the likelihood of the top specialty not participating in the survey process. AMA staff indicated that during the RUC level of interest (LOI) process, they review each item to ensure the dominant specialty from claims data and/or the CPT CCA are planning to be involved in the survey. If the dominant specialty did not indicate that they would participate, AMA staff reach out to ask them to participate or explain why they are not. This may involve other courses of action if the specialty does not believe their members should be dominant, such as CPT Assistant articles. The Subcommittee also discussed whether there should be any updates to the *RUC Reviewer Process Guidelines* document to remind reviewers to consider the dominant specialty in the claims data relative to the survey data. AMA staff noted that the list of items included in that document confirmed by AMA staff include, “Specialty Representation: Confirm specialties developing recommendations are the dominant specialties performing the service overall and in the non-facility setting.”

The Research Subcommittee also discussed whether specific criteria should be developed on when to use only the dominant specialty survey data when developing recommendations. The Subcommittee concurred that at this time it is most appropriate to handle these situations on a case-by-case basis instead of implementing explicit criteria.

The Research Subcommittee recommends to maintain the current process of assessing these issues on a case-by-case basis and no changes are warranted at this time.

Discussion – Survey Intensity and Complexity Questions

At the October 2021 RUC meeting, two RUC members requested that the Research Subcommittee review the intensity questions on the survey and previous data from surveys to determine if any improvements may be made to this section of the survey. The intensity and complexity questions were most recently reviewed by the Research Subcommittee at the April 2020 meeting; at that time, the Research Subcommittee agreed that no changes were necessary to either the intensity and complexity measures nor to any of the RUC processes instructions documentation with respect to intensity and complexity. AMA staff conducted the following analysis to assist the Subcommittee in its January 2022 discussion, using all RUC surveyed codes for CPT 2020-CPT 2022:



The Research Subcommittee had a robust discussion on potential factors causing the right skew of the data, the utility of the intensity and complexity questions as they currently stand and whether any changes were warranted at this time. The Chair noted that, although the summary data is not a bell curve, that is perhaps to be expected given the survey respondents are asked to select the reference code that is most like the survey code. It is unclear what factors are causing few respondents to rate their reference code as less intense than the survey code. One possibility is that perhaps respondents often select the closest reference service without selecting a more intense reference service as the reference services lists (RSLs) are ordered by work RVU lowest to highest. The “much less” and “much more” intense choices are also relatively infrequently selected; this is perhaps due to the survey respondents being asked to select a reference service from the RSLs that is most similar to the survey code.

Several subcommittee members noted that the intensity and complexity summary data still has utility and has been a fundamental part of the RUC process. Several subcommittee members noted that RUC reviewers should keep in mind the tendencies of survey respondents when considering these data. AMA staff noted that some of the utility of asking the intensity/complexity questions is indirect, in that the questions have the survey respondents consider intensity/complexity definitions and each intensity factor, immediately before they provide their work RVU estimates for each survey code.

Two Subcommittee members noted opined that perhaps a Likert scale represented by a single score for each question should be considered. Other Subcommittee members noted that the current survey questions are already a Likert scale, though now instead of being represented by a single score (as was the case until 2016), the summary data includes the range of choices made by the survey respondents.

Several Subcommittee members noted that, although it is an interesting tendency, the skew of the dataset is not sufficient to warrant action. **The Research Subcommittee agreed that no changes are**

necessary at this time to either the intensity and complexity measures or to any of the RUC processes instructions documentation with respect to intensity and complexity.

During the RUC's discussing of the Research Subcommittee report, several RUC members observed that the right skew of the intensity and complexity data is not unique to the RUC process and is also seen in a lot of surveys unrelated to the RUC process as well. A RUC member noted that the tendencies for this question have remained stable over time and the RUC reviewers should just be cognizant of these tendencies when reviewing these data.

Discussion – Review of Services Undergoing Global Period Change

At the October 2020 RUC meeting, a RUC member requested for the consideration and development of policies regarding how neutral evaluation of codes undergoing a change in global period should be best accomplished. Global period assignments are proposed by specialty societies to CMS through the RUC process; CMS determines the global periods. The RUC referred this issue to the Research Subcommittee to discuss the process for reviewing services with a proposed global period change, and whether, if any new policies should be developed.

At the January discussion, the Subcommittee reiterated that it would never be appropriate to use a straight reverse building block methodology and if any action was taken, it should only pertain to the rules for when compelling evidence is required. Between the October and January meetings, the Chair, Vice Chair and AMA Staff had several discussions regarding this topic. Both the Vice Chair and Chair summarized their positions following these sessions. The Vice Chair stated that 010-day and 090-day globals converting to 000-day global codes should not be presented or viewed in the same way as a de novo new 000-day global codes, and that some sort of process should be established for addressing global period conversions. He noted that perhaps budget neutrality and compelling evidence would be the best mechanism to address their concern. The Chair expressed concern that establishing a hard rule would set a new RUC precedent and potentially result in unintended outcomes and that these conversions are relatively rare.

Subcommittee members noted that certain services have IWPUTs that are near zero or negative, which would leave essentially no value for the procedure itself if some sort of formulaic approach were implemented. It was also noted that all of the tabs with global period changes presented to date have included compelling evidence. Others noted that it is unclear how common these conversions will be going forward and whether it is premature to move beyond handling these situations case-by-case.

The RUC should continue to monitor the issue and may wish to discuss policy and methodology if global period conversions increase in frequency. In the meantime, the few instances of these conversions will continue to be reviewed on a case-by-case basis.

The RUC approved the Research Subcommittee Report.

XV. Health Care Professionals Advisory Committee (HCPAC) (Tab 22)

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

The HCPAC Review Board reviewed changes to HCPAC MPC list including codes that were removed because the current valuation for these codes in the Medicare Physician Payment Schedule and in the RUC database, are not RUC recommended. The removed codes would need to be

resurveyed to be put back on the MPC list and go through the full RUC process for valuation. At that point, the surveyed codes could be re-considered for the HCPAC MPC list.

In addition, the HCPAC reviewed the addition of CPT code 96105 to the HCPAC Multi-Specialty Points of Comparison (MPC) list nominated by the American Speech-Language-Hearing Association (ASHA). **The HCPAC voted to accept the addition of CPT code 96105 to the HCPAC MPC list.**

The RUC filed the HCPAC report as presented.

XVI. Rotating Seat Election

Donna E. Sweet, MD, MACP, American College of Physicians, was elected to the RUC's Primary Care rotating seat.

Adam Weinstein, MD, Renal Physicians Association, was elected to the RUC's Internal Medicine rotating seat.

The term for the rotating seats is two years, beginning in March 2022 and ending in February 2024 with the provision of final recommendations to CMS for the 2025 Medicare Physician Payment Schedule.

XVII. New/Other Business

New Business Resulting in Referral to a RUC Subcommittee/Workgroup

Referral to Administrative Subcommittee

A RUC member inquired about the current compelling evidence guidelines. The member requested clarification on the standards and guidelines associated with the application of compelling evidence during RUC discussions. The member noted that RUC deliberations could benefit from aligning the terminology used to describe compelling evidence standards. The member requested that this issue be referred to the Administrative Subcommittee for review of the current guidelines to standardize the language and clarify the intent of compelling evidence. Examples of language clarification were provided such as streamlining and defining terms like "dominant specialty" and "primary specialty". This inquiry prompted a robust discussion that resulted in consensus regarding the need to provide language clarification within the current guidelines to ensure accuracy when discussing compelling evidence during RUC deliberations. Additionally, a Subcommittee member requested the background for when CMS codified the compelling evidence standards in rulemaking.

The RUC requests that the Administrative Subcommittee review the current compelling evidence to clarify and/or streamline the terminology. The Administrative Subcommittee will not review the addition of additional criteria for compelling evidence at this time.

Referral to the Relativity Assessment Workgroup (RAW)

A RUC member inquired about the gender equity issue discussed by the RAW and suggested that the preventive medicine services codes 99381-99397 could be reviewed by the RAW for gender based misvaluation. The member stated that preventive medicine services are valued by age, not gender, and provided an example that care for a 30 year old male and 30 year old female have significant differences such as the need for gynecological care. These differences impact the time, physician work, and practice expense for a preventive visit based on the patient's gender suggesting the need for

further review of gender-based variations of care. The RUC member also noted that the physician's gender plays a role in the physician's patient population which adds another level of potential physician payment inequity. The member requested that the issue be referred to the RAW for review of potential misvaluation of preventive care codes based on gender-related patient care. This request was met with support from several other RUC members.

The RUC concluded to refer this item to the RAW for further review of gender-based differences in preventive medicine services.

The RUC adjourned at 5:15 p.m. CT on Saturday, January 15, 2022.