

**AMA/Specialty Society RVS Update Committee**  
**Naples Grande Beach Resort, Naples, FL**  
**January 11-14, 2023**

**Meeting Minutes**

**I. Welcome and Call to Order**

The RUC met in-person and virtually in January 2023. Doctor Ezequiel Silva, III called the hybrid meeting to order on Thursday, January 12, 2023, at 1:00 p.m. ET. The following RUC Members and RUC Alternates were in attendance:

**RUC Members:**

Ezequiel Silva, III, MD  
Amr Abouleish, MD, MBA  
Margie C. Andreae, MD  
Amy Aronsky, DO  
James Blankenship, MD, MHCM  
Robert Dale Blasier, MD  
Audrey Chun, 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  
M. Douglas Leahy, MD  
Scott Manaker, MD, PhD  
Bradley Marple, MD  
John H. Proctor, MD, MBA  
Marc Raphaelson, MD  
Richard Rausch, DPT, MBA  
Kyle Richards, MD  
Christopher Senkowski, MD  
Donna Sweet, MD  
G. Edward Vates, MD  
James C. Waldorf, MD  
Thomas J. Weida, MD  
Adam Weinstein, MD  
David Wilkinson, MD, PhD

**RUC Alternates:**

Jennifer Aloff, MD  
Anita Arnold, MD  
Gregory L. Barkley, MD  
Eileen Brewer, MD  
Leisha Eiten, AuD  
William Gee, MD  
Martha Gray, MD  
David C. Han, MD  
John Heiner, MD  
Gwenn V. Jackson, MD  
Kris Kimmell, MD  
Alan Lazaroff, MD  
Mollie MacCormack, MD  
Lance Manning, MD  
John McAllister, MD  
Swati Mehrotra, MD  
Matthew Press, MD  
Sanjay A. Samy, MD  
James L. Shoemaker, MD  
Clarice Sinn, DO  
Michael J. Sutherland, MD  
Deepali Tukaye, MD  
Mark T. Villa, MD  
Mark Villa, MD  
David Yankura, MD  
Robert Zwolak, MD

## II. Chair's Report

Ezequiel Silva III, MD, Chair of the AMA/Specialty Society RVS Update Committee (RUC), introduced himself and welcomed everyone to the in-person RUC meeting. He explained the virtual component of the meeting and that virtual participants would be able to view the meeting proceedings in webinar format. Additionally, he reminded participants of RUC confidentiality provisions, general expectations for the meeting, and highlighted the importance of conference 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. However, this meeting is being recorded by the AMA.
  - The full confidentiality agreement can be found on the RUC Collaboration site (Structure and Functions).
  
- Doctor Silva conveyed the Lobbying Policy:
  - “Lobbying” means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
  - Any communication that can reasonably be interpreted as inducement, coercion, intimidation, or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
  - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
  - Full lobbying policy found on Collaboration site (Structure and Functions).
  
- Doctor Silva reviewed the financial disclosures:
  - RUC members completed a statement of compliance with the RUC Financial Disclosure Policy.
  - There were no stated disclosures/conflicts for this meeting.
  
- Doctor Silva conveyed the following information on the virtual and in-person components:
  - Virtual attendees are in listen-in-only mode.
  - All meeting registrations received the Zoom link.
  - In-person attendees may follow along on the screens in the room or the shared screen on Zoom.
  
- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff (in-person):
  - Perry Alexion, MD
  - Edith Hambrick, MD
  - Gift Tee
  
- Doctor Silva welcomed the CMS virtual attendees:
  - Ayush Arora
  - Tamika Brock
  - Erika Carrera
  - Larry Chan

- Arkaprava Deb, MD
  - Zehra Hussain
  - Kathleen Kersell
  - Morgan Kitzmiller, MHA
  - Sarah Leipnik
  - Ann Marshall
  - Mikayla Murphy
  - Karen Nakano, MD
  - Julie Rauch
  - Patrick Sartini
  - Pamela Foxcroft Villanyi, MD
  - Pamela West
- Doctor Silva welcomed the following Contractor Medical Director:
    - Janet Lawrence, MD
    - Barry Whites, MD (virtual)
    - Richard Whitten, MD (virtual)
  - Doctor Silva welcomed the following Members of the CPT Editorial Panel:
    - Lawrence Simon, MD – CPT Panel Member
  - Doctor Silva announced departing RUC Members:
    - Sergio Bartakian, MD (SCAI)
    - Daniel DeMarco, MD (ACG/AGA/ASGE)
    - Alan Lazaroff, MD (AGS)
  - Doctor Silva announced the new RUC Members:
    - David Wilkinson, MD (CAP)
  - Doctor Silva thanked departing RUC Members and Advisors for their years of service and contributions the RUC process:
    - Joseph Schlecht, DO (AOA)
    - Guy Orangio, MD (ASCRS)
    - Dee Adams Nikjeh, PhD (AHSA)
  - Doctor Silva announced the RUC reviewer guidelines:
    - To enable more efficient RUC reviews, AMA staff shall review specialty Summary of Recommendation forms (SORs) for adherence to the general guidelines and expectations, such as:
      - Specialty representation
      - Survey methodology
      - Vignette
      - Sample size
      - Budget Neutrality / Compelling evidence
      - Professional Liability Insurance (PLI)
  - Doctor Silva shared the following procedural issues for RUC members:
    - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue, and it will be reflected in the minutes.
    - RUC members or alternates sitting at the table may not present or debate for their society.

- Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
- Doctor Silva conveyed the following procedural guidelines related to Voting:
  - Work RVU and Direct Practice Expense Inputs = 2/3 vote
  - Motions = Majority vote
  - RUC members will vote on all tabs using the single voting link provided via email.
  - You will need to have access to a computer or smartphone to submit your vote.
  - If you are unable to vote during the meeting, please notify AMA staff.
  - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports.
  - If members are going to abstain from voting, please notify AMA staff so we may account for all 29 votes.
  - If specialty society presenters require time to deliberate, please notify the RUC Chair.
  - If RUC advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC chair or AMA staff.
- Doctor Silva stated the following procedural guidelines related to RUC Ballots:
  - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.
  - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
  - You must enter the work RVU, physician times and reference codes to support your recommendation.
- Doctor Silva shared the process for reviewing Research Subcommittee recommendations:
  - The Research Subcommittee meeting reports are always included in the Research Subcommittee folder.
  - For ease, now you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.
- Doctor Silva shared election information from the Administrative Subcommittee:
  - The Administrative Subcommittee reviewed and approved the nominations for Any Other and Internal Medicine rotating seats; and
  - Reviewed the rotating seat policies and election rules.

### **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 announced the RUC Chair Reappointment:
  - Ezequiel Silva III, MD, has been reappointed to a second term (out of three possible two-year terms) as RUC Chair
  - Doctor Silva's second term will be from March 1, 2023 – February 28, 2025
- Ms. Smith provided updates regarding the RUC Subcommittee's and Workgroups:
  - The Subcommittee and Workgroup composition are restructured every two years coinciding with the Chair's term.
  - The Subcommittee and Workgroups will be restructured for the April 2023 meeting.

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- After this meeting, AMA Staff will send out a questionnaire to RUC Members, RUC Alternates, RUC Advisors, HCPAC Members and HCPAC Alternates to gauge which Subcommittees and Workgroups they are interested in serving.
- Ms. Smith conveyed the following information regarding the Practice Expense data collection effort:
  - The AMA is working with Mathematica to initiate a new practice expense data collection effort.
  - Data would be collected and analyzed in 2023 and 2024, based on 2022 cost data
  - The AMA has met with HHS and CMS to discuss the effort.
  - Pilot studies and practice interviews were conducted in 2020 and Summer 2022.
  - Draft survey questions were circulated to specialty societies for review (September 26 and December 12, 2022).
  - Proposed methodology and sample distribution by specialty was circulated (December 12, 2022).
- Ms. Smith reviewed the RUC Database application:
  - The RUC database is available at <https://rucapp.ama-assn.org>
  - Orientation is available on YouTube at <https://youtu.be/3phyBHWxlms>
  - Accessible both online and offline from any device, including smartphones and tablets
  - Download 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.
  - The database reflects 2021 data.
  - 2023 Medicare RBRVS – The Physicians’ Guide is available.
- 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 and 2025 Cycle:

<b>RUC Recommendation Due Date</b>	<b>RUC Meeting</b>	<b>Location</b>	<b>CPT Cycle</b>
Apr 4, 2023	Apr 26-29, 2023	San Diego, CA	CPT 2025
Aug 29, 2023	Sep 27-30, 2023	Chicago, IL	CPT 2025
Dec 12, 2023	Jan 17-20, 2024	San Diego, CA	CPT 2025

#### **IV. Approval of Minutes from the September 2022 RUC Meeting**

The RUC approved September 2022 RUC meeting minutes as submitted.

## V. CPT Editorial Panel Update

Lawrence Simon, MD provided the following CPT Editorial Panel update on the September 2022 Panel meeting, response to the COVID-19 pandemic, CPT Ad Hoc Workgroups, and upcoming CPT meetings:

- Panel meeting activity in response to COVID-19 pandemic:
  - Covid Vaccine: To date, 58 CPT Category I codes have been created to describe manufacturer specific Covid vaccine codes.
    - The latest release on November 30, 2022, included two codes (0173A, 91317). These codes are intended for Pfizer vaccine for children 6 months to 4 years as a bivalent, third dose after the administration of the first (0081A) and 2nd (0082A) doses of the 91308 product.
- February 2023 CPT Editorial Panel meeting:
  - 37 items of business
  - Notable agenda items:
    - 3 Digital medicine related CCAs
    - 10 Category III code applications
  - E/M Revisions –Revise codes 99202-99205, 99211-99215, eliminating time ranges for each of these codes, revise reporting instructions in various guidelines throughout the E/M section; revise reporting instructions in the guidelines for Prolonged Service with or without Direct Patient Contact codes 99417-99418. These changes are all proposed as editorial to be effective 1/1/2024.
    - The result of work from the Joint CPT/RUC E/M Workgroup
  - Telemedicine Office Visits - Establish 17 codes and guidelines for reporting telemedicine services.
    - The result of work by the CPT/RUC Telemedicine Office Workgroup
  - Appendix P and T Criteria - Revise Criteria for evaluating inclusion of services in Appendix P (synchronous audio-visual) and Appendix T (synchronous audio-only) telemedicine services.
    - The result of work by the Appendix P/T Workgroup
- CPT Ad Hoc Workgroups:
  - Tumor Genomics Neoplastic Targeted GSP Workgroup
    - Co-Chairs: Lawrence Simon, MD and Aaron Bossler, MD
    - Workgroup Charge: To create CPT coding solution(s) for extended/comprehensive genomic testing in tumor/neoplastic conditions, including whole genome sequencing. In the deliberation process, the workgroup will utilize information gained in the AMA's July 2021 Diagnostic Precision Medicine Coding and Payment meeting to determine the feasibility of more granular coding solutions within this space. If deemed appropriate the workgroup may additionally suggest a more granular coding solution for non-neoplastic genomics testing.
    - The Tumor Genomics Testing Workgroup submitted a CCA (Tab 11) for the February Panel meeting requesting to revise codes 81445-81456, establish codes 81457-81464, and revise the guidelines in the Genomic Sequencing Procedures and Other Molecular Multianalyte Assays subsection to reflect current practice in genomic sequencing technology for somatic mutation and cancer treatment.

- Appendix P-T Workgroup
  - Co-Chairs: David M. Kanter, MD, MBA and Richard A. Frank, MD, PhD
  - Workgroup Charge: To develop objective criteria for the Panel to utilize for maintenance of the list of CPT codes listed in Appendix P and if deemed appropriate the Workgroup will provide suggested edits to the Appendix P introduction guidelines. In such edits, the Workgroup should consider modification of the Appendix P title, relative to Appendix T, and relevant modification of introductory language in Appendix T, as deemed appropriate.
  - The Workgroup reconvened on October 24th, 2022, to review and revise based on the feedback provided by the Executive Committee at the September 2022 meeting. The workgroup submitted a CCA that includes new criteria for inclusion of CPT codes in Appendices P and T, revision to the title of appendix P and addition of new questions regarding the criteria to the Code Change Application. The work of the group is represented in Tab 38 at the February 2023 CPT Editorial Panel Meeting.
- CPT/RUC Telemedicine Office Visits Workgroup
  - Co-Chairs: Chris Jagmin, MD and Peter Hollmann, MD
  - Workgroup Charge: The workgroup will assess available data and determine appropriate next steps to determine accurate coding and valuation, as needed, for E/M office visits performed via audio-visual and audio only modalities.
  - The CPT/RUC Telemedicine Office Workgroup was charged with assessing available data and determining appropriate next steps for accurate coding and valuation, as needed, for E/M office visits performed via audio-visual and audio-only modalities. Currently modifier 95 does not define precise practice expense inputs associated with the service (non-facility setting). Medicare had indicated that 151 days following the end of the public health emergency (PHE) telemedicine office visits (office visits reported with modifier 95) the policy of facility rate will be reinstated. The CAA extended this to 1/1/2024. The workgroup determined that a coding solution was needed to account for practice expense for clinical staff time for both audio-video and audio-only office visits. The work of the group is represented in Tab 42 at the February 2023 CPT Editorial Panel Meeting.
- February 2-4, 2023, Panel Meeting
  - The next Panel meeting is February 2-4, 2023 (Thursday-Saturday) in La Jolla, CA
  - Annual CPT HCPAC Advisory Committee Meeting –Thursday, February 2. Topics include:
    - CPT Technology Update
    - Appendix S –AI Taxonomy: A Users Guide
    - CPT Literature Review: Overview of the LOE and Addressing Pressing Questions
    - Updates and Education on Health Equity and DEI Plans
  - The next application submission deadline is February 6, 2023 (for May 4-6, 2023, Panel meeting)

## **VI. Centers for Medicare & Medicaid Services Update**

Gift Tee, MPH, Director, Division of Practitioner Services, provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the 2023 Medicare Physician Payment Schedule (MFS) Final Rule.

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- CMS 2023 Final Rule Highlights
  - On November 2, 2022, 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, 2023. Comments on the Proposed Rule were due by September 6, 2022. Some of the topics covered in the Final Rule included:
    - CY 2023 PFS Ratesetting and Conversion Factor updates
    - Geographic Practice Cost Indices (GPCI) and Malpractice (MP) data update
    - Updated Medicare Economic Index (MEI) for CY 2023
    - Evaluation and Management (E/M) Services
    - Telehealth and Other Services Involving Communications Technology
    - Dental and Oral Health Services
    - Behavioral Health Services
    - Chronic Pain Management
    - Skin Substitutes
    - Direct access to Audiologists
    - Colorectal Cancer Screening
  
- Consolidated Appropriations Act 2023
  - Following the release of the CY 2023 PFS Final Rule, the Consolidated Appropriations Act, 2023 (P.L. 117-3XX) was enacted on December 29, 2022. The law included several provisions that impact Medicare payments for physicians and other health professionals, including a provision that increases the payment amounts for services paid under the PFS in calendar years 2023 and 2024 by 2.5 percent and 1.25 percent, respectively. The increases in fee schedules are exempt from budget neutrality requirements and would not factor into any determinations of fee schedule amounts in future years.
  
- CY 2023 PFS Ratesetting and Conversion Factor
  - The Social Security Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than \$20 million; if they do, CMS applies a budget neutrality adjustment. For CY 2023, the budget neutrality adjustment is - 1.60 percent.
  - Approximately 90 percent of the budget neutrality adjustment to the PFS conversion factor is attributable to the revaluation of Other E/M services with the remaining 10 percent due to other finalized policy proposals. CMS acknowledges that the clinical labor pricing update is responsible for significant shifting of spending between specialties, however these changes are reflected in changes to the PE RVUs for individual services and do not affect the conversion factor.
  - The PFS conversion factor as initially finalized reflected the statutory update of 0.00 percent for CY 2023 and the adjustment necessary to account for changes in relative value units and expenditures that resulted from the finalized policies.
  - The CY 2023 PFS Final Rule presents a series of standard technical changes involving practice expense, including the implementation of the second year of the clinical labor pricing update, and standard rate-setting refinements.
  - The Protecting Medicare and American Farmers From Sequester Cuts Act, 2022 provided a temporary 3.00 percent increase in PFS payments for CY 2022, which is due to expire for CY 2023.
  - With the budget neutrality adjustment to account for changes in RVUs (required by law), the expiration of the 3.0 percent payment increase provided for CY 2022 by the Protecting Medicare and American Farmers From Sequester Cuts Act, the finalized CY



- 2023 PFS conversion factor was calculated as \$33.06, a decrease of \$1.55 to the CY 2022 PFS conversion factor of \$34.61.
- However, the Consolidated Appropriations Act, 2023 provided a temporary 2.5 percent payment increase in PFS payments for CY 2022. Consequently, the finalized CY 2023 PFS conversion factor is \$33.89, a decrease of \$0.72 from the CY 2022 PFS conversion factor of \$34.61.
  - Clinical Labor Update – Year 2
    - In consideration of stakeholder comments, last year CMS finalized the proposal to update the clinical labor rates for CY 2022 through the use of a four-year transition period. CMS used a four-year transition to incorporate new pricing data in the past and believes that the use of a phased transition will help provide payment stability and maintain beneficiary access to care.
    - CY 2023 is the second year of the clinical pricing update. For CY 2023, CMS finalized pricing increases for four clinical labor types, Lab Tech/Histotechnologist(L035A), Histotechnologist(L037B), Angio Technician (L041A), and Mammography Technologist (L043A). The CY 2023 pricing for all other clinical labor types would remain unchanged from the pricing finalized in the CY 2022 PFS Final Rule.
    - The impacts of the clinical labor rate update on PFS payments are largely driven by the share that labor costs represent of the direct PE inputs for each service. Specialties and services with a substantially lower or higher than average share of direct costs attributable to clinical labor will experience declines or increases, respectively.
  - Practice Expense (PE) Data Comment Solicitation
    - As discussed in last year’s rulemaking, 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 the Agency 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 CMS bases these costs.
    - CMS solicited comments from interested parties to inform CMS strategic plans to develop and implement a routine and transparent process for updating the variety of practice expense data used to develop PFS payment rates.
  - Overall, CMS believes their 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. CMS believes 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.
- Geographic Practice Cost Indices (GPCI) and Malpractice (MP) Data Update
    - Medicare statute requires us to update the data that CMS uses to reflect resource cost differences in different service areas at least every three years. This year CMS updated the work, practice expense, and malpractice GPCIs, which measure resource cost differences among localities compared to the national average.
    - In addition to the requirement to update the data at least every three years, the statute also requires that the data updates be phased in over two years. Therefore, the CY 2023 GPCIs are a 50/50 blend of the previous year's GPCI value and the updated GPCI value

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for each locality. The GPCI update will be fully implemented in CY 2024 when the phase-in is complete.

- As statute requires, CMS updated the data inputs used to calculate the MP RVUs. The update includes technical refinements intended to improve stability in the system by expanding the use of available specialty specific premium data, draw on experience and engagement with interested parties that have asked CMS to continue to improve the malpractice RVU calculation methodologies and use as much comprehensive data as possible.
- Updated Medicare Economic Index (MEI) for CY 2023
  - CMS finalized the proposed rebasing and revising of the 2017-based MEI with some technical revisions to the proposed method based on public comments.
  - CMS proposed to rebase and revise the MEI for CY 2023 and solicited comments regarding the future use of the 2017-based MEI weights in PFS ratesetting and the GPCIs.
  - The proposed method for determining the 2017-based MEI relies on estimating base year expenses from publicly available data from the U.S. Census Bureau NAICS 6211 Offices of Physicians.
  - The proposed methodology allows for the use of data that are more reflective of current market conditions of physician ownership practices, rather than only reflecting costs for self-employed physicians, and would allow for the MEI to be updated on a more regular basis since the proposed data sources are updated and published on a regular basis.
  - Finalizing the use of the 2017-based MEI cost weights to set PFS rates would not change overall spending on PFS services, but would result in significant distributional changes to payments among PFS services across specialties and geographies.
  - In consideration of ongoing efforts to update the PFS payment rates with more predictability and transparency, and in the interest in ensuring payment stability, CMS proposed not to use the updated MEI cost share weights to set PFS payment rates for CY 2023. However, CMS solicited comments on the potential use of the proposed updated MEI cost share weights to calibrate payment rates and update the GPCI under the PFS in the future.
  - The final CY 2023 MEI update is 3.8 percent based on the most recent historical data available. As noted above, the rebased and revised MEI weights were not used in CY 2023 PFS ratesetting.
- E/M Services – Office/Outpatient (CY 2021)
  - For CY 2021, CMS finalized several policies that took into account the changes to E/M visit codes, as explained in the AMA CPT Codebook, which took effect January 1, 2021.
  - CMS finalized revaluation of the following code sets that include, rely upon or are analogous to office/outpatient E/M visits commensurate with the increases in values finalized for office/outpatient E/M visits for CY 2021:
    - End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services
    - Transitional Care Management (TCM) Services
    - Maternity Services
    - Cognitive Impairment Assessment and Care Planning
    - Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness Visits (AWV)
    - Emergency Department Visits
    - Therapy Evaluations
    - Psychiatric Diagnostic Evaluations and Psychotherapy Services

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- CMS clarified the definition of HCPCS add-on code G2211 (formerly referred to as GPC1X), previously finalized for office/outpatient E/M visit complexity, and refined utilization assumptions for this code.
- CMS finalized separate payment for a new HCPCS code, G2212, describing prolonged office/outpatient E/M visits to be used in place of CPT code 99417 (formerly referred to as CPT code 99XXX) to clarify the times for which prolonged office/outpatient E/M visits can be reported.
- E/M Services – Other E/M’s
  - As part of the ongoing updates to E/M visit codes and related coding guidelines that are intended to reduce administrative burden, the AMA CPT Editorial Panel approved revised coding and updated guidelines for Other E/M visits, effective January 1, 2023.
  - Similar to the approach, CMS finalized in the CY 2021 PFS Final Rule for office/outpatient E/M visit coding and documentation, CMS finalized and adopted most of these AMA CPT changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) effective January 1, 2023.
  - This revised coding and documentation framework includes CPT code definition changes (revisions to the Other E/M code descriptors), including:
    - New descriptor times (where relevant).
    - Revised interpretive guidelines for levels of medical decision making.
    - Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
  - Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).
- E/M Services – Prolonged Services
  - Prolonged service codes function like add-on codes, providing additional payment for extended visits per additional time increment.
  - The CPT Editorial Board restructured the prolonged service codes that apply to the Other E/M visit code sets for 2023.
  - CMS is concerned that the revised CPT prolonged service framework will allow for duplicative or unwarranted billing, pose barriers to oversight, and increase administrative complexity compared to the predecessor codes.
  - Therefore, CMS finalized creation of Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services. These services will be reported with three separate Medicare-specific G codes.
- E/M Services – Split (or Shared) Services
  - For CY 2023, CMS finalized a year-long delay of the split (or shared) visits policy established in rulemaking for 2022. This policy determines which professional should bill for a shared visit by defining the “substantive portion,” of the service as more than half of the total time. Therefore, for CY 2023, as in CY 2022, the substantive portion of a visit is comprised of any of the following elements:

- History
  - Performing a physical exam
  - Making a medical decision
  - Spending time (more than half of the total time spent by the practitioner who bills the visit).
- As finalized, clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, or more than half of the total practitioner time spent to define the “substantive portion” instead of using total time to determine the substantive portion, until CY 2024.
- Telehealth and Other Services Involving Communications Technology
    - For CY 2023, CMS finalized a number of policies related to Medicare telehealth services under PFS including: making several services that are temporarily available as telehealth services for the PHE, available through 2023 on a Category III basis, to allow additional time for the collection of data that could support their eventual inclusion as permanent additions to the Medicare Telehealth Services list.
    - CMS finalized the proposal to allow physicians and practitioners to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person. These claims will require the modifier “95” to identify them as services furnished as telehealth services. Claims can continue to be billed with the place of service code that would be used if the telehealth service had been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends.
    - Consolidated Appropriations Act, 2022 (CAA)
      - CMS confirmed their intention to implement the telehealth provisions in sections 301 through 305 of the CAA, 2022, via program instruction or other sub-regulatory guidance to ensure a smooth transition after the end of the PHE. These policies, such as allowing telehealth services to be furnished in any geographic area and in any originating site setting (including the beneficiary’s home); allowing certain services to be furnished via audio-only telecommunications systems; and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services, will remain in place during the PHE for 151 days after the PHE ends. The CAA, 2022, also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.
    - CAA, 2023
      - The relevant provisions of the CAA, 2023 extend Medicare Telehealth flexibilities through the end of CY 2024. The practical effect is that the relevant provisions of the CAA, 2022 that describe an extension period of 151 days have no more effect.
    - Virtual Supervision
      - For the duration of the PHE, to limit infection exposure, CMS revised the definition of direct supervision to include virtual availability of the supervising physician or practitioner using interactive audio/video real-time communications technology.
      - CMS will continue this policy through the end of the year in which the PHE ends.
      - In the 2022 and 2023 Final Rules, CMS solicited comments on whether this revised definition should continue following the PHE, and if so, in what circumstances.

- Remote Therapeutic Monitoring (RTM)
  - In the CY 2023 PFS NPRM, CMS proposed payment for RTM services using four new HCPCS G codes instead of the CPT codes that were previously established. This policy was intended to address coding and billing concerns raised by interested parties.
  - As part of the proposal, the Agency also discussed their interest in the types of data collected, how the data that are collected solve specific health conditions and what those health conditions are, the costs associated with RTM devices that are available to collect RTM data, how long the typical episode of care by condition type might last, and the potential number of beneficiaries for whom an RTM device might be used by the health condition type.
  - In consideration of the public comments, CMS finalized a policy to use the existing CPT codes that were created for CY 2022, while they consider the broader RTM landscape, and future RTM related coding.
- Dental and Oral Health Services
  - Medicare payment for dental services is generally precluded by statute. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition.
  - Effective for CY 2023, CMS 1) finalized a proposal to clarify and codify certain aspects of the current Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition, and 2) other clinical scenarios under which Medicare Part A and Part B payment can be made for dental services, such as dental exams and necessary treatments prior to, or contemporaneously with, organ transplants, cardiac valve replacements, and valvuloplasty procedures.
  - CMS also finalized payment for dental exams and necessary treatments prior to the treatment for head and neck cancers starting in CY 2024 and finalizing a process in CY 2023 to review and consider public recommendations for Medicare payment for dental service in other potentially analogous clinical scenarios.
  - Finally, the Agency is working to address commenters' thoughtful feedback and questions regarding the operational aspects of billing and claims processing for these services.
- Behavioral Health Services
  - In the 2022 CMS Behavioral Health (BH) Strategy, CMS set a goal to improve access to, and quality of, mental health care services.
  - In light of the current needs among Medicare beneficiaries for improved access to behavioral health services, CMS considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). CMS finalized the proposal to add an exception to the direct supervision requirement under "incident to" regulation at 42 CFR 410.26 to allow behavioral health services provided under the general supervision of a physician or NPP, rather than under direct supervision, when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or NPP). CMS believes that this change will facilitate utilization and extend the reach of behavioral health services.
  - CMS also finalized a proposal to create a new general Behavioral Health Integration (BHI) code describing a service personally performed by CPs or clinical social workers (CSWs) to account for monthly care integration where the mental health services

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furnished by a CP or CSW are serving as the focal point of care integration. Further, CMS finalized a proposal to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.

- CMS also clarified that any service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel under the general supervision of a physician or NPP who is authorized to furnish and bill for services provided incident to their own professional services.
  - CMS indicated in the Final Rule the intention to address payment for new codes that describe caregiver behavioral management training in CY 2024 rulemaking.
  - Effective January 1, 2024, the BH provision establishes a new Medicare benefit category for LMFT services and Mental Health Counselors (MHC) services furnished by and directly billed by LMFTs and MHCs, respectively. LMFT and MHC services are defined as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital). An LMFT or MHC is defined as an individual who possesses a master's or doctor's degree, is licensed or certified by the State in which they furnish services, and who has performed at least 2 years of clinical supervised experience, and meets other requirements as the Secretary determines appropriate.
  - Additionally, effective January 1, 2024, the BH provision requires the Secretary to increase the fee schedule amount for psychotherapy for crisis services to 150 percent of the non-facility fee schedule amount when services are furnished in certain settings such as the home or a mobile unit.
- **Chronic Pain Management Services**
    - CMS finalized the creation of new HCPCS codes G3002 and G3003 and valuation for chronic pain management and treatment services (CPM) for CY 2023. CMS believes the CPM HCPCS codes will improve payment accuracy for these services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have chronic pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.
    - The finalized codes include a bundle of services furnished during a month that the Agency believes to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders. CMS finalized the CPM codes to include the following elements in the code descriptor:
      - diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and coordination between relevant practitioners furnishing care, such as physical and occupational therapy, complementary and integrative care approaches, and community-based care, as appropriate.
  - **Skin Substitutes**
    - CMS proposed several changes to the policies for skin substitute products to streamline the coding, billing, and payment rules and to establish consistency with these products across the various settings.
      - Specifically, CMS proposed to change the terminology of skin substitutes to 'wound care management products',

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- and to treat and pay for these products as incident to supplies under the PFS beginning on January 1, 2024.
  - After reviewing comments on the proposals, CMS understands that it would be beneficial to provide interested parties more opportunity to comment on the specific details of changes in terminology, coding, and payment mechanisms prior to finalizing a specific date when the transition to more appropriate and consistent payment and coding for these products will be completed.
  - CMS is conducting a virtual Town Hall in later this month to address commenters' concerns as well as discuss potential approaches to the methodology for payment of skin substitute products under the PFS.
  - CMS will take into account the comments received in response to CY 2023 rulemaking and feedback received in association with the Town Hall in order to strengthen proposed policies for skin substitutes in future rulemaking.
- Audiologists
  - CMS finalized a policy to allow beneficiaries direct access to an audiologist without an order from a physician or NPP for non-acute hearing conditions.
  - The finalized policy will allow the use of a new modifier — instead of using a new HCPCS G-code as proposed — because the Agency was persuaded by the commenters that a modifier would allow for better accuracy of reporting and reduce burden for audiologist. The service(s) can be billed using the codes audiologists already use with the new modifier and include only those personally furnished by the audiologist.
  - The finalized direct access policy will allow beneficiaries to receive care for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. This modification in the finalized policy necessitates multiple changes to the CMS claims processing systems, which will take some time to fully operationalize, but audiologists may use modifier AB, along with the finalized list of 36 CPT codes, for dates of service on and after January 1, 2023.
  - CMS finalized the proposal to permit audiologists to bill for this direct access (without a physician or practitioner order) once every 12 months, per beneficiary. Medically reasonable and necessary tests ordered by a physician or other practitioner and personally provided by audiologists will not be affected by the direct access policy, including the modifier and frequency limitation.
- Colorectal Cancer Screening
  - For CY 2023, CMS finalized, two updates to expand the Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations:
    - CMS is expanding Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment and coverage limitation from 50 to 45 years.
    - CMS is expanding the regulatory definition of colorectal cancer screening tests to include a complete colorectal cancer screening, where a follow-on screening colonoscopy after a Medicare covered noninvasive stool-based colorectal cancer screening test returns a positive result. A functional outcome of the policy for a complete colorectal cancer screening will be that, for most beneficiaries, cost sharing will not apply for either the initial stool-based test or the follow-on colonoscopy.
  - Both policies reflect the desire to expand access to quality care and to improve health outcomes for patients through prevention and early detection services, as well as through

effective treatments. The revised colorectal cancer screening policies directly advance CMS health equity goals by promoting access for much needed cancer prevention and early detection in rural communities and communities of color that are especially impacted by the incidence of colorectal cancer.

- The policies also directly support President Biden’s Cancer Moonshot Goal to cut the death rate from cancer by at least 50 percent over the next 25 years and addresses his recent proclamation of March 2022 as National Colorectal Cancer Awareness Month.
- Mr. Tee addressed questions from the attendees:
  - A RUC member thanked Mr. Tee for addressing the E/M coding changes in the manuals and Med Learn Matters (MLN) articles. However, the RUC member explained that information from a 2022 MLN article written about the 95- and 97- documentation guidelines included outdated information. The MLN article stated that for 2021 E/M-Office Visits, CMS followed CPT guidelines but then expands on documentation which the majority of, if not all, is not applicable today. The RUC member and AMA staff kindly requested for the outdated MLN article to be taken down until it is revised. AMA Staff further inquired about the possibility of reaching out to the Recovery Audit Contractor (RAC) auditors to inform them that some of the RAC auditors are relying on outdated information. The AMA has been notified that physicians are having to appeal audits but are finding little success because of the outdated MLN document.

## VII. Contractor Medical Director Update

Janet I. Lawrence, MD, MS, FACP, Medicare Contractor Medical Director (CMD), provided the CMD update.

- Workgroups
  - MIGS (Micro-invasive Glaucoma Surgery) Workgroup
    - Subject Matter Expert (SME) Contractor Advisory Committee (CAC) on January 5<sup>th</sup> for MIGS in general
    - Goniotomy specifically
  - Pain Management Workgroup
    - Sacroiliac joint Injection/RFA (Radiofrequency Ablation) Local Coverage Determinations (LCD) completed -see your MAC’s Website
  - Pricing Workgroup
    - Very active
    - Regular meetings with associations and industry (to obtain information to determine the most accurate pricing)
  - CAC Engagement workgroup
  - New ones are being created as the need arises
    - National Coverage Determinations (NCD) retirement workgroup
    - Botox workgroup
    - Dental services workgroup
    - Other workgroups in the works
- Artificial Intelligence (AI) – Machine Learning (ML) – 2023 Agenda
  - Develop standard technology assessment criteria for MAC adoption
  - Increase transparency regarding what is considered investigational or experimental with AI-ML enabled technology
  - Host stakeholder meetings discussing AI-ML enabled technology
  - Develop AI-ML Subject Matter Expert (SME) database

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- Develop and maintain technology and coding database of AI-ML enabled technology
- Increase discussions with CMS and FDA for guidance on policy development (eg, scope and process development)
- Develop pricing methodology and framework for AI-ML enabled technology
- Continue collaborative calls with AMA, bi-annual
- Dental Services
  - Code of Federal Regulations (CFR) – 42 CFR 411.15
    - 42 CFR §411.15 -Particular services excluded from coverage
    - (i) 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
      - (1) The individual's underlying medical condition and clinical status; or
      - (2) The severity of the dental procedures
    - \*Specifically, §411.15(i)(3)(i) has been amended, to allow for payment under Medicare Part A and Part B for dental services, furnished in an inpatient or outpatient setting, that are inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services.
  - Key Statements
    - No payment is made for dental services when an excluded service is the primary procedure involved.
    - Dental services will continue to be contractor priced, for which payment is made currently, and for the dental services that can be made under the amendments to §411.15(i)(3) for CY 2023 and CY 2024, and until CMDs have further data.
    - Services to be paid under the applicable payment system.
    - CMDs will make payment when a Doctor of Dental Medicine or dental surgery (referred to as a dentist) furnishes dental services that are an integral part of the covered primary procedure or service furnished by another physician, or non-physician practitioner, treating the primary medical illness.
      - If there is no exchange of information, or integration, between the medical professional (physician or other non-physician practitioner) in regard to the primary medical service and the dentist in regard to the dental services, then there would not be an inextricable link between the dental and covered medical service within the meaning of the regulation at §411.15(i)(3).
- Doctor Lawrence addressed questions from the attendees:
  - A RUC member inquired about dental coverage. In the CMD and CMS presentations, the intricacies of dental and medical coverage were detailed, specifically regarding the regulation requiring dental care to be integral to the medical care. The RUC member asked whether there would be an opportunity for public comment on the dental coverage described in the Final Rule. The RUC member noted that the relationship between dental care and medical care is important, as the CMD presentation described, however, there is potential for loopholes between the two and non-essential dental care has the potential to put further downward pressure on the conversion factor. Doctor Lawrence responded that generally speaking, CMDs have the same questions and concerns. In regard to public comment, CMDs are waiting on further guidance, however, CMDs anticipate the development of an LCD. CMS has expressed openness and interest in hearing provider's concerns to better understand the nuances of the dental benefit. Once CMDs receive

concrete guidance, we will try to define the dental benefit. When the CMDs and CMS reach the potential creation of an LCD then, most definitely, there will be opportunity for public comment.

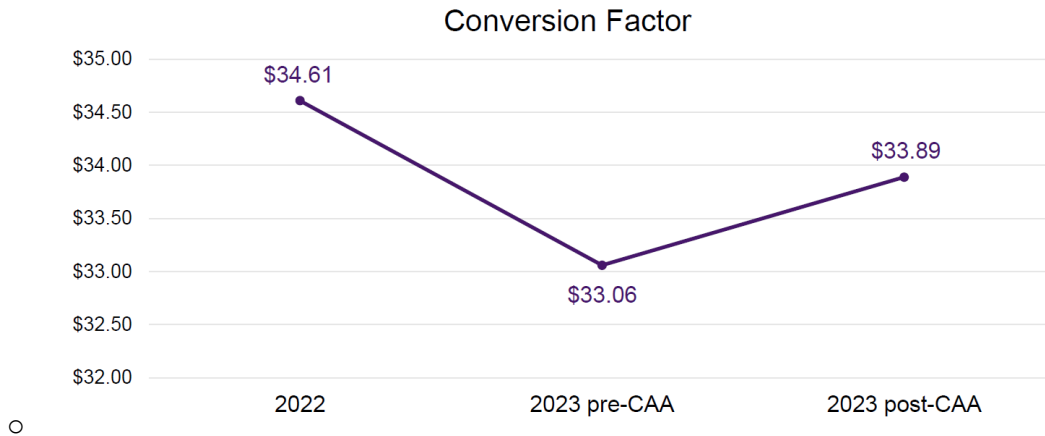
- A RUC member inquired about the dental services expansion under both Medicare Part A and Part B. The member further stated that throughout the Final Rule and the CMS and CMD presentations at the meeting, there was not discussion or clarity provided on how dental services are going to be funded under Medicare. Doctor Lawrence stated that CMDs have the same question. Mr. Tee confirmed that CMS is looking at dental services that are integral or connected to medical services, and further clarified that CMS is thinking of about this from a Part B perspective versus from a Part A perspective. Doctor Lawrence agreed and offered an example regarding transplant services and appropriate timing of dental care that needs to be addressed prior to transplantation. CMDs are finding little guidance on how to proceed with the dental benefit in this instance. A RUC member agreed with the example and noted that it is an excellent example of how the costs may be allocated between Part A and Part B. Specifically, dental care for an organ transplant would be performed ahead of time, but the costs of acquiring an organ are allocated to Part A rather than Part B. Further, it may be within CMS and CMD purview to determine how the funds will be divided between Part A and B.
- A RUC member responded again on the dental services discussion providing an additional example related to restorative function not related to pre-dental work, but the restorative work that is done for lifelong congenital anomalies or a trauma incident. Specifically, the member inquired about the scope of the dental services. Doctor Lawrence responded that CMDs are working with the dental societies and continuing to work with CMS to address questions, likely the same ones that the RUC has currently. CMS appreciates the comments and questions and invites RUC participants to continue submitting those as we work through the benefit.
- AMA staff requested clarification on the 3 indications for dental services. Mr. Tee responded that they are the scenarios that CMS described in the Final Rule.

## VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, American Medical Association, provided the Washington report focusing on the AMA response to the 2023 Medicare Physician Payment Schedule Final Rule.

- Medicare Conversion Factor (CF)
  - CMS estimated a 2023 CF of \$33.06, or a 4.5% decrease from 2022, due to:
    - Expiration of the 3% increase funded by Congress in CY 2022
    - Additional ~1.5% budget neutrality decrease stemming from revisions to more E/M code sets, including inpatient, emergency department (ED), and nursing facility
  - Organized medicine [strongly urged](#) Congress to stop the full 4.5% cut
  - Consolidated Appropriations Act (CAA) of 2023 offset 2.5% of cut to Medicare conversion factor in 2023
    - Offsets 1.25% of CF reduction in 2024
    - Delayed 4% pay-go cuts until 2025
  - CMS revised the 2023 CF to \$33.89
- Impact of Consolidated Appropriations Act (CAA), 2023
  - The graphic illustrates the 2022 conversion factor (\$34.61), 2023 pre-CAA (\$33.06), 2023 post-CAA (33.89) conversion factor

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- AMA statement on Medicare cuts in 2023
  - “The AMA is extremely disappointed and dismayed that Congress failed to prevent Medicare cuts next year, threatening the financial viability of physician practices and endangering access to care for Medicare beneficiaries. This 2% cut following two decades of flat payment rates will have consequences on health care access for older Americans. High inflation compounds the threat to practice viability because physicians are the only Medicare providers without annual inflation-based updates. We are deeply worried that many practices will be forced to stop taking new Medicare patients – at a time when access to care is already inadequate. Congress must immediately begin the work of long-overdue Medicare physician payment reform that will lead to the program stability that beneficiaries and physicians need.” - Jack Resneck Jr., M.D., President, American Medical Association
- What’s next?
  - The AMA –in collaboration with over 120 other physician and health care organizations – has outlined the [essential principles](#) that can put the nation’s health care system on sustainable financial ground
  - In [response](#) to a congressional request for information, the AMA went into more detail about establishing a rational Medicare payment system:
    - End the freeze to the CF and provide an inflationary update
    - Fix budget neutrality, including correcting for past overestimates, raising the \$20 million trigger, and exempting services
    - Reform Merit-based Incentive Payment System (MIPS) and expand Alternative Payment Model (APM) opportunities
  - At its most recent meeting, MedPAC [acknowledged](#) the growing gap between the costs of practicing medicine and what Medicare pays
- 2023 Medicare Physician Payment Schedule
  - CMS finalized a one-year delay requiring a physician to see a patient for more than half of the total time of a split or shared visit to bill for the service
  - CMS will continue paying for telehealth services provided by office-based physicians at the non-facility rate through CY 2023
  - For non-face-to-face remote therapeutic monitoring (RTM) services, CMS did not finalize its proposal for four new G-codes and agreed to allow for general supervision when physicians and other QHPs use the RTM treatment management services

- CMS adopted RUC's recommendation values for vaccine administration services and will update payments for preventive vaccine administration services by the annual increase to the Medicare Economic Index (MEI)
- CMS expanded access to colorectal cancer screening, which will help promote cancer prevention and early detection within rural and minoritized and marginalized communities that are especially impacted by the incidence of colorectal cancer
- Medicare Shared Savings Program (MSSP)
  - Growth in MSSP Accountable Care Organizations (ACOs) has plateaued. Higher spending populations are increasingly left out of ACOs. Access to ACOs appear inequitable.
  - To reverse these trends, CMS finalized sweeping changes to MSSP:
    - Providing advanced shared savings payments to low revenue ACOs that are new to MSSP
    - Extending the timeline for ACOs to participate in a one-sided risk track in order to invest in infrastructure and care delivery redesign processes
    - Establishing a health equity adjustment of up to 10 bonus points to an ACO's quality score
    - Revising MSSP benchmarking policies
- Merit-based Incentive Payment System (MIPS)
  - In response to AMA advocacy, CMS extended the deadline to submit a hardship exception due to the ongoing COVID-19 PHE for 2022
    - [Applications](#) are due by March 3 (previously due Jan. 3)
    - If impacted in any way by COVID-19 during the 2022 performance period, submit a hardship exception application to avoid a 2024 penalty
  - MIPS 2022 data submission deadline is March 31, 2023
  - 2023 MIPS payment adjustments, based on 2021 scores, now apply
  - CMS maintained a 75-point performance threshold for 2023, which is the minimum score required to avoid a penalty
  - Note that the \$500 million exceptional performance bonus pool expired
- MIPS Value Pathways (MVPs)
  - MVPs are a voluntary MIPS participation option starting in 2023
  - 12 MVPs, including:
    - Optimizing Chronic Disease Management
    - Improving Care for Lower Extremity Joint Repair
  - MVP participants have the option to form subgroups at the specialty level
  - AMA submitted detailed recommendations in response to an RFI about MVPs
- Alternative Payment Models (APMs)
  - In response to concerted advocacy from the AMA and other stakeholders, Congress in the CAA of 2023:
    - Provides a 3.5% APM incentive payment for qualifying participants in 2023, which will be paid in 2025
      - The prior incentive payment of 5% expires in the 2024 payment year based on 2022 participation
    - Maintains the thresholds to determine which APM participants are eligible for the incentive payments
      - The payment threshold stays at 50% in 2023 instead of jumping to 75%

- [AMA's Recovery Plan for America's Physicians](#)
  - Support telehealth to maintain coverage and payment
  - Stop scope creep that threatens patient safety
  - Fix prior authorization to reduce the burden on practices and minimize care delays for patients
  - Reduce physician burnout and address the stigma around mental health
  - Reform Medicare payment to promote thriving physician practices and innovation
  
- Telehealth
  - AMA has been strongly advocating to make permanent the telehealth flexibilities established during the COVID-19 PHE
  - In the year-end spending deal, Congress advanced telehealth beyond the PHE by extending telehealth flexibilities until Dec. 31, 2024, regardless of when the PHE ends
    - Allows telehealth services to be furnished in any geographic location and setting, including a beneficiary's home
    - Delays the in-person visit requirements for mental health services furnished via telehealth
  - Previously, these flexibilities were set to expire 152 days after the PHE ended
  
- Prior Authorization (PA)
  - CMS has repropose a PA rule, with updates from its original 2020 NPRM.
  - In response to AMA advocacy, CMS is now proposing that Medicare Advantage Organizations (MAO) are subject to new PA requirements. Impacted payers include MAOs, Medicaid and CHIP fee-for-service, Medicaid managed care plans, CHIP managed care entities, qualified health plans and federally-facilitated exchanges.
  - CMS proposes several new PA process requirements. Impacted payers must:
    - Support new technology that interoperates with EHRs. This should allow physicians to automate the exchange of information regarding PA requirements, documentation, and decisions.
    - Send information to physicians regarding the specific reason for a PA denial.
    - Respond to a PA request within certain timeframes (not applicable to QHP or FFEs).
    - Publicly report certain metrics about payers' PA processes for transparency.
  - CMS' proposals would go into effect starting January 2026.
  
- Additional provisions in the Omnibus Bill
  - The AMA strongly supported the Retirement Parity in Student Loans Act, which permits retirement plans (ex. 401(k) and SIMPLE IRA) to make matching contributions to workers as if their student loan payments were salary reduction contributions
  - Congress also provided funding for 200 additional GME slots. Half of the total is devoted to psychiatry or psychiatry subspecialties
    - These additional slots are an important down payment but not nearly enough slots to meet the needs of patients or to address the larger physician shortage of between 54,100 and 139,000 physicians by 2033
    - The AMA strongly supports the Resident Physician Shortage Reduction Act that would provide an additional 14,000 residency slots (2,000 per year for the next 7 years)

- Ms. Hananoki addressed questions from the attendees:
  - A RUC member commented on the economic impact of expensive drugs, supplies, and equipment now used in the office setting that were formerly used in the outpatient hospital setting. Further, an economic example comparing the impact of shifting from hospital and outpatient settings to physician offices for procedures, expenses, high cost disposables, and supplies and understanding how much of that has contributed to the downward pressure on the conversion factor would be very useful.
  - A RUC member made a statement about AMA efforts related to Electronic Health Record (EHR) systems, mental health, and prior authorization. Specifically, the member made a comment about Medicare Advantages plans acquiring information from EHRs and that there is fragmentation between smaller mental health EHR systems and their ability to interact with the larger systems. Further, the mental health crisis is illuminating these technological issues and the related variations of EHR systems based on unique requirements state-by-state. Ms. Hananoki acknowledged these concerns and recommendations.

## IX. Relative Value Recommendations for CPT 2024

### **Dorsal Sacroiliac Joint Arthrodesis (Tab 4)**

**Trent Emerick, MD (ASRA), Damean Freas, MD (NANS), Robert Kennedy, MD (SIR), Minhajuddin Khaja, MD (SIR), Michael Lubrano, MD (ASIPP), Andy Moriarity, MD (ACR), Lauren Nicola, MD (ACR), Gerald Niedzwiecki, MD (OEIS), John Ratliff, MD (AANS), Richard Rosenquist, MD (ASA), Clemens Schirmer, MD, PhD (CNS), Karin Swartz, MD and Bradley Wargo, MD (ASIPP)**

In May 2022, the CPT Editorial Panel created Category III code 0775T for CPT 2023 to report percutaneous sacroiliac (SI) joint arthrodesis using an intra-articular implant(s), such as bone allograft material or synthetic devices. In September 2022, the Panel deleted category III code 0775T for CPT 2024 and created new Category I code 27278, which was surveyed for the January 2023 RUC meeting. CPT codes 27279 *Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device* and 27280 *Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed* were added as family codes to the level of interest (LOI) form. The specialty societies do not consider codes 27279 and 27280 as part of the same code family, providing the following rationale:

- The surgical approach in the new interpositional procedure (27278) typically involves the posterior or dorsal approach to the SI joint, which contrasts with CPT code 27279 transfixing procedures and the 27280 open procedure, both of which approach the joint from the lateral (ilium) side of the body.
- At the September 2022 CPT Panel meeting, no substantive changes were made to codes 27279 or 27280, aside from only one revision of a single exclusionary parenthetical to account for the conversion of Category III code 0775T to Category I code 27278.
- CPT code 27280 does not have a comparable clinical relationship to the new percutaneous work involved in 27278, and a distinctly different group of physicians will be performing 27278 (interventional pain physicians and interventional radiologists).
- CPT code 27279 was reviewed by the RUC in 2014 and 2018.

Given this information, the specialty societies requested that these codes not be re-reviewed with 27278 at the January 2023 RUC meeting. **The RUC submits no recommendation regarding CPT codes 27279 and 27280 as they were not re-reviewed or re-surveyed in conjunction with 27278.**

***27278 Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device***

The RUC reviewed the survey results from a random sample of 34 anesthesiologists, pain medicine physicians, interventional radiologists and orthopedic surgeons and determined that the survey 25<sup>th</sup> percentile work RVU of 7.86 accounts for the physician work required to perform 27278. The RUC recommends 33 minutes pre-service evaluation time, 10 minutes pre-service positioning, 11 minutes pre-service scrub/dress/wait time, 46 minutes intra-service time, 20 minutes post-service time for this service, 0.5-99238 discharge visit and 2-99213 office visits, equaling 185 minutes of total time.

The RUC noted that selected pre and post standard time packages were modified to more accurately reflect pre- and post-service time involved with this service, as supported by the survey. The RUC concurred with the specialties that 10 minutes of pre-positioning time is typical to account for placing the patient in the prone or oblique positioning on the procedure table, padding bony prominences and assessing or adjusting the position of the extremities and head as necessary. The RUC agreed that these time allotments are clinically appropriate and sufficient for this service.

Regarding post-operative care, the RUC agrees with the inclusion of 0.5-99238 discharge visit and 2-99213 office visits to perform post-operative care within the 090-day global period. The specialty societies noted that 2-99213 visits are typical for this procedure. During the first post-operative visit, approximately two weeks after surgery, the patient's wound is examined, healing is assessed, and the absence of infection is confirmed. The physician would also assess the patient's pain score and write medication, occupational and/or physical therapy orders, as necessary. During the second post-operative visit, approximately six weeks after surgery, the physician would order and review imaging to assess functional recovery of the sacroiliac joint arthrodesis and implant to verify and ensure that appropriate fusion with the bone has occurred. Assessment of the patient's pain score, medication management, occupational and/or physical therapy orders, as necessary, would again take place, and the physician may revise treatment plan(s) and communicate with the patient and family/caregiver and primary physician.

To justify a work RVU value of 7.86, the RUC compared CPT code 27278 to the top key reference service code 22869 *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level* (work RVU = 7.03, 43 minutes intra-service time and 194 minutes total time). The RUC recognizes that code 22869 is a strong point of comparison to the survey code in terms of intra-service time, total time and intensity. For additional support, the RUC also referenced CPT code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU= 7.39, 45 minutes intra-service time, 199 minutes total time) and noted that the surveyed code is a somewhat more intense and complex procedure to perform and would have appropriate relativity with this reference service. The RUC concluded that CPT code 27278 should be valued at the 25<sup>th</sup> percentile as supported by the survey. **The RUC recommends a work RVU of 7.86 for CPT code 27278.**

### **Practice Expense**

The Practice Expense (PE) Subcommittee discussed the direct practice expense inputs, including the new high-cost supply item, *Dorsal SI Joint Arthrodesis Implant*, and made several modifications. The Subcommittee reviewed the vignette, which specifies a single implant and concurred that one supply input would be typical.

The addition of clinical staff code L041A *Vascular Interventional Technologist*, formerly, *Angio Technician*, was approved to accurately represent the clinical staff labor type that is typical for performing this service in a non-facility setting. The specialties clarified that there are three individual staff in the room for this procedure plus the physician. There is a Vascular Interventional Technologist who assists the physician 100% of the time as noted by the 46 minutes in CA018. There is a second Vascular Interventional Technologist whose time is divided between two staff types as accounted for by the split in minutes for CA020 *Assist physician or other qualified healthcare professional* between L041A and L037D *RN/LPN/MTA*. This Vascular Interventional Technologist both assists and circulates, assisting the physician for 75% of the time and then reported as a nurse blend for 25% when the individual is acting as a circulator. The circulating staff person in the room acquires images, opens supplies, adjusts and connects equipment. This by convention has been a 75% L041A / 25% L037D role for interventional procedures. There is also a nurse present solely for the anesthesia monitoring. The PE Subcommittee emphasized that the inputs related to the provision of moderate sedation are included in the moderate sedation code. Therefore, the minutes for CA017 *Sedate/apply anesthesia* and CA022 *Monitor patient following procedure/service, multitasking 1:4* were removed. In addition, the supply inputs were modified to account for moderate sedation and eliminate any duplication. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

### **New Technology**

CPT code 27278 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

### **Vertebral Body Tethering (Tab 5)**

**John Ratliff, MD (AANS), Clemens Schirmer, MD, PhD (CNS); Kevin Neal, MD (AAOS), William Creevy, MD (AAOS), Hussein Ekousy, MD (AAOS) and Kano Mayer, MD (NASS)**

At the October 2020 CPT Panel meeting, two CPT Category III codes were approved for vertebral body tethering. At the September 2022 CPT Panel meeting, the Category III codes were revised to only describe anterior lumbar or thoracolumbar tethering and two new Category I codes (22836 and 22837) were established for thoracic tethering. In addition, another new Category I code (22838) was established for tether revision, replacement or removal. In preparation for the January 2023 RUC meeting, a multi-specialty survey for 22836-22838 was prepared and randomly distributed to members of the representative specialties. The survey was also sent to a vendor list of surgeons trained in tether device placement.

Anterior vertebral body tethering (VTB) is a non-fusion spinal procedure intended to obtain and maintain surgical correction of progressive adolescent idiopathic scoliosis in growing children. VTB immediately corrects spinal curvature and increases mobility and flexibility, as opposed to posterior spinal fusion (PSF), tethering allows for additional correction based on a child's potential remaining growth. Two surgeons work together, one surgeon who performs the approach and a second surgeon, typically a spine surgeon, to attach screws to specific vertebral bodies on the convex side of the spine before connecting them using a flexible polyethylene-braided cord called a tether. The tether is then placed under tension to minimize the magnitude of curvature, which enables the spine to continue straighter growth. Over time, the vertebral bodies will ideally reshape and sustain this correction



independently rather than rely on the tensioned tether as the child gets older. Continued progression without intervention is a potential outcome of this treatment but tethering revision is also a possibility. The typical patient for this service is skeletally immature, has failed or is intolerant to bracing and has an osseous structure that is dimensionally adequate to accommodate screw fixation. The RUC noted that these services are typically performed by co-surgeons and were surveyed as such using a custom survey template approved by the Research Subcommittee. The specialty societies and RUC agreed that the work RVU valuation is reflective of the total work required to perform the procedure. For example, if one surgeon had the technical competence to perform this procedure without working with another surgeon, the appropriate CPT code would be selected once; however, if two surgeons performed the procedure as co-surgeons, each physician would report the code with modifier 62. The work RVU would be multiplied by 1.25 and then divided equally between the co-surgeons (i.e., 62.5%). Any pre-evaluation coordination time, standby intra-service time or asynchronous post-operative time has been accounted for in the survey methodology. The RUC agrees that the time allotments and physician work involved with these codes is representative of the technical aptitude and clinical nuance required to perform this service.

**22836 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments**

The RUC reviewed the survey results from pediatric orthopaedic surgeons and pediatric neurosurgeons and determined that the survey median work RVU of 32.00 appropriately accounts for the physician work required to perform 22836. The RUC recommends 60 minutes pre-service evaluation time, 30 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 210 minutes intra-service time, 45 minutes immediate post-service time, 1-99231, 1-99232, 1-99933, 1-99238, 2-99213 and 1-99214 visits for this service, which equals 599 minutes of total time.

The specialty societies selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The selected standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. The additional 20 minutes of pre-service evaluation time above the standard pre-time package time of 40 minutes accounts for both co-surgeons to review the preoperative imaging (X-ray, MRI, CT) and discuss the planned procedure, including approach, index procedure, and closure. Both surgeons will also independently meet with the anesthesiologist and patient prior to the procedure. An additional 27 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for work by both co-surgeons. The scoliosis will require additional and special lateral decubitus positioning for this procedure, not only to be able to maneuver the patient during surgery to place the tether, but also to allow the approach surgeon the ability to expose the spine (including typical deflation of the lung) and continue to work alongside the second surgeon who is performing the index procedure. Positioning also needs consideration of placement of imaging equipment. The 5-minute reduction in pre-service scrub/dress/wait time, to 15 minutes, is consistent with the median time indicated by the survey respondents.

The RUC agrees with the specialties' recommendation of 45 minutes for immediate post-service time. The 12-minute increase from the package time recognizes that each co-surgeon has different post-operative care concerns, including the need for both surgeons to write separate operative notes and orders, meet with the patient and family independently, and monitor post-operative recovery.

The RUC discussed the number and level of postoperative hospital and office visits and agreed that they fairly represent the total work of both surgeons who will independently be monitoring the patient related to their own intraoperative work. The RUC recognizes that typically each co-surgeon will conduct at least two separate post-operative visits related to their operative procedures. The first visit for the neurosurgeon or orthopaedic surgeon ("spine" Surgeon B) includes a comparison of subjective

and objective pre-operative versus post-operative elements of function, dressings removal and wound assessment, medication management, activity guidance and discussion of physical and occupational therapy needs and goals. Shared decision making and assessment of the patient will be required to determine if further imaging or testing is required, including whether an X-ray should be ordered if there are concerns for iatrogenic instability. Overall progress is discussed with referring physician(s) and dictated for the patient's medical chart. The first visit for the "approach" surgeon (Surgeon A) includes a review of the spine surgeon's (Surgeon B's) notes, pathology report and post-discharge labs and films, an interval update of H&P, examination and assessment of the patient's wounds for the presence of post-operative hematoma/seroma and the potential need for aspiration and monitor for pneumothorax or pulmonary insufficiency. Surgeon A will review the patient's activity and restrictions, perform medication management, remove sutures/staples when appropriate and complete progress notes for the medical chart and continue discussion between the co-surgeons and referring physician(s). Additional visits by both co-surgeons, as appropriate for each surgeon, will continue medication management, PT/OT progress review and order revision and the continued assessment of patient progress as deemed necessary.

To justify a work RVU value of 32.00, the RUC compared CPT code 22836 to the top key reference service 22207 *Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar* (work RVU = 36.68, 300 minutes intra-service time and 758 minutes total time) and the second highest key reference service 22551 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2* (work RVU = 25.00, 120 minutes intra-service time and 395 minutes total time). The RUC recognizes that the surveyed code is appropriate relative to the two key reference services, bracketed in terms of intra-service time, total time, physician work and intraoperative intensity. For additional support, the RUC referenced CPT codes 22865 *Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar* (work RVU = 31.75, 210 minutes of intra-service time and 600 minutes of total time) and 35637 *Bypass graft, with other than vein; aortoiliac* (work RVU = 33.05, 210 minutes of intra-service time and 605 minutes of total time), noting that together these two codes bracket the survey median work RVU and have nearly identical intra-service and total time as 22836. **The RUC recommends a work RVU of 32.00 for CPT code 22836.**

**22837 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments**

The RUC reviewed the survey results from pediatric orthopaedic surgeons and pediatric neurosurgeons and determined that the survey median work RVU of 35.50 appropriately accounts for the physician work required to perform 22837. The RUC recommends 60 minutes pre-service evaluation time, 30 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 260 minutes intra-service time, 45 minutes post-service time, 1-99231, 1-99232, 1-99933, 1-99238, 2-99213 and 1-99214 visits for this service, which equals 649 minutes of total time.

The specialty societies selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. The additional 20 minutes of pre-service evaluation time above the standard pre-time package time of 40 minutes accounts for both co-surgeons to review the preoperative imaging (X-ray, MRI, CT) and discuss the planned procedure, including approach, index procedure, and closure. Both surgeons will also independently meet with the anesthesiologist and patient prior to the procedure. An additional 27 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for work by both co-surgeons. The scoliosis will require additional and special lateral decubitus positioning for this procedure, not only to be able to maneuver the patient during

surgery to place the tether, but also to allow the approach surgeon the ability to expose the spine (including typical deflation of the lung) and continue to work alongside the second surgeon who is performing the index procedure. Positioning also needs consideration of placement of imaging equipment. The 5-minute reduction in pre-service scrub/dress/wait time, to 15 minutes, is consistent with the median time indicated by the survey respondents.

The key distinction between CPT codes 22837 and 22836 is reflected in the number of vertebral segments that are involved with each procedure. Curve correction is dependent on the tensioning of the polyethylene-braided tether cord being used across vertebral segments. The typical work associated with 22836 involves a vertebral body tethering construct that applies to 7 or fewer vertebral segments, while 22837 applies to 8 or more segments. The 50-minute increase in intra-service time from 210 to 260 minutes between 22836 and 22837 reflects this clinical difference, as the tether in use will be longer when tensioning between a greater number of vertebral segments. It is also important to note that despite the slight decline in intraoperative intensity of work for 22837 compared to 22836 when accounting for the longer tether cord that is in use, the physician work in and of itself is no more intense or complex between these two services.

The RUC agrees with 45 minutes of immediate post-service time. The 12-minute increase from the package time recognizes that each co-surgeon has different post-operative care concerns to address including the need for both surgeons to write separate operative notes and orders, meet with the patient and family independently, and monitor post-operative recovery.

The RUC discussed the number and level of postoperative hospital and office visits and agreed that they fairly represent the total work of both surgeons who will independently be monitoring the patient related to their own intraoperative work. The RUC recognizes that typically each co-surgeon will conduct at least two separate post-operative visits related to their operative procedures. The first visit for the neurosurgeon or orthopaedic surgeon (“spine” Surgeon B) includes a comparison of subjective and objective pre-operative versus post-operative elements of function, dressings removal and wound assessment, medication management, activity guidance and discussion of physical and occupational therapy needs and goals. Shared decision making and assessment of the patient will be required to determine if further imaging or testing is required, including whether an X-ray should be ordered if there are concerns for iatrogenic instability. Overall progress is discussed with referring physician(s) and dictated for the patient’s medical chart. The first visit for the “approach” surgeon (Surgeon A) includes a review of the spine surgeon’s (Surgeon B’s) notes, pathology report and post-discharge labs and films, an interval update of H&P, examination and assessment of the patient’s wounds for the presence of post-operative hematoma/seroma and the potential need for aspiration and monitor for pneumothorax or pulmonary insufficiency. Surgeon A will review the patient’s activity and restrictions, perform medication management, remove sutures/staples when appropriate and complete progress notes for the medical chart and to continue discussion between the co-surgeons and referring physician(s). Additional visits by both co-surgeons, as appropriated for each surgeon, will continue medication management, PT/OT progress review and order revision and the continued assessment of patient progress as deemed necessary.

To justify a work RVU value of 35.50, the RUC compared CPT code 22837 to the top key reference service 22207 *Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar* (work RVU = 36.68, 300 minutes intra-service time and 758 minutes total time) and the second highest key reference service 22551 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2* (work RVU = 25.00, 120 minutes intra-service time and 395 minutes total time). The RUC recognizes that the surveyed code is appropriately relative to the two key reference services, bracketed in terms of intra-service time, total

time, physician work and intraoperative intensity. For additional support, the RUC referenced CPT codes 61537 *Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery* (work RVU = 36.45, 265 minutes of intra-service time and 614 minutes of total time) and 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment* (work RVU = 37.53, 265 minutes of intra-service time and 682 minutes of total time) noting that together these two codes bracket the survey median work RVU and have nearly identical intra-service and total time as 22837. **The RUC recommends a work RVU of 35.50 for CPT code 22837.**

**22838 Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed**

The RUC reviewed the survey results from pediatric orthopaedic surgeons and pediatric neurosurgeons and determined that the survey median work RVU of 36.00 appropriately accounts for the physician work required to perform 22838. The RUC recommends 60 minutes pre-service evaluation time, 30 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 260 minutes intra-service time and 45 minutes post-service time for this service, 1-99231, 1-99232, 1-99933, 1-99238, 2-99213 and 1-99214 visits for this service, which equals 649 minutes of total time.

The specialty societies selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc.* The standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. The additional 20 minutes of pre-service evaluation time above the standard pre-time package time of 40 minutes accounts for both co-surgeons to review the preoperative imaging (X-ray, MRI, CT) and discuss the planned procedure, including approach, index procedure, and closure. Both surgeons will also independently meet with the anesthesiologist and patient prior to the procedure. An additional 27 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for work by both co-surgeons. The scoliosis will require additional and special lateral decubitus positioning for this procedure, not only to be able to maneuver the patient during surgery to place the tether, but also to allow the approach surgeon the ability to expose the spine (including typical deflation of the lung) and continue to work alongside the second surgeon who is performing the index procedure. Positioning also needs consideration of placement of imaging equipment. The 5-minute reduction in pre-service scrub/dress/wait time, to 15 minutes, is consistent with the median time indicated by the survey respondents.

The primary distinction between CPT code 22838 and the other two vertebral body tethering codes in this family is that the typical work involved with 22838 is a revision, replacement or removal of the previously inserted tether. There is a potential for increased interoperative intensity of physician work involved with 22838 based on the complexity and complications that could occur with the revision or modification of the initial procedure. The longer tether and greater tensioning required also contributes to the overall intensity of work. Similar to 22837, 22838 includes a 50-minute increase in intra-service time from 210 to 260 minutes from 22836, as this service will likely involve 8 or more vertebral segments as opposed to 7 or fewer. The work RVU increase from 35.50 to 36.00 between 22837 and 22838 accounts for the overall increase in intensity and complexity of service.

The RUC agrees with 45 minutes of immediate post-service time. The 12-minute increase from the package time recognizes that each co-surgeon has different post-operative care concerns to address including the need for both surgeons to write separate operative notes and orders, meet with the patient and family independently, and monitor post-operative recovery.

The RUC discussed the number and level of postoperative hospital and office visits and agreed that they fairly represent the total work of both surgeons who will independently be monitoring the patient related to their own intraoperative work. The RUC recognizes that typically each co-surgeon will conduct at least two separate post-operative visits related to their operative procedures. The first visit for the neurosurgeon or orthopaedic surgeon (“spine” Surgeon B) includes a comparison of subjective and objective pre-operative versus post-operative elements of function, dressings removal and wound assessment, medication management, activity guidance and discussion of physical and occupational therapy needs and goals. Shared decision-making and assessment of the patient will be required to determine if further imaging or testing is required, including whether an X-ray should be ordered if there are concerns for iatrogenic instability. Overall progress is discussed with referring physician(s) and dictated for the patient’s medical chart. The first visit for the “approach” surgeon (Surgeon A) includes a review of the spine surgeon’s (Surgeon B’s) notes, pathology report and post-discharge labs and films, an interval update of H&P, examination and assessment of the patient’s wounds for the presence of post-operative hematoma/seroma and the potential need for aspiration and monitor for pneumothorax or pulmonary insufficiency. Surgeon A will review the patient’s activity and restrictions, perform medication management, remove sutures/staples when appropriate and complete progress notes for the medical chart and continue discussion between the co-surgeons and referring physician(s). Additional visits by both co-surgeons, as appropriated for each surgeon, will continue medication management, PT/OT progress review and order revision and the continued assessment of patient progress as deemed necessary.

To justify a work RVU value of 36.00, the RUC compared CPT code 22838 to the top key reference service 22207 *Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar* (work RVU = 36.68, 300 minutes intra-service time and 758 minutes total time) and the second highest key reference service 22861 *Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical* (work RVU = 33.36, 180 minutes intra-service time and 477 minutes total time). The RUC recognizes that the surveyed code is appropriately relative to the two key reference services, 22207 and 22861 in terms of intra-service time, total time, physician work and intraoperative intensity. For additional support, the RUC referenced CPT codes 61537 *Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery* (work RVU = 36.45, 265 minutes of intra-service time and 614 minutes of total time) and 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment* (work RVU = 37.53, 265 minutes of intra-service time and 682 minutes of total time) noting that together these two codes bracket the survey median work RVU and total time and have nearly identical intra-service time as 22838. Lastly, the RUC compared code 22838 to 22837. Although both codes have the same time and visit details and same total time, the RUC agreed with the survey respondents that the work for revising a tethering device was slightly more intense because the operation is being performed through scarred tissue from the implantation procedure. The RUC determined that the difference of 0.50 work RVUs was justified. **The RUC recommends a work RVU of 36.00 for CPT code 22838.**

### **Practice Expense**

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee agreed that the additional 15 minutes of clinical staff time to the standard 090-day global package is in accordance with other co-surgeon, 62-modifier codes, involving multidisciplinary coordination of care by clinical staff of co-surgeons prior to the procedure. This additional time was included under CA008 *Perform regulatory mandated quality assurance activity* which is consistent with the most recent CMS assignment for additional 15 minutes for co-surgery in the Medicare Physician Fee schedule 2019 Proposed Rule. It was also noted

that these inputs are for a pediatric patient population so EF023 *table, exam* is typical as opposed to the use of a power table for adult patients with spine pain and disease. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

#### **New Technology**

CPT codes 22836, 22837 and 22838 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

#### **RAW Flag**

The RUC recommends flagging CPT 22838 since the survey response was below 30. This service will be reviewed by the Relativity Assessment Workgroup in three years. At that time, the specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.

#### **RUC Database Flag**

The RUC and specialty societies agreed that CPT code 22838 should be marked as “Do not use to validate physician work” in the RUC database given the low survey response.

#### **Phrenic Nerve Stimulation System (Tab 6)**

**Charles Bae, MD (AASM), Richard Wright, MD (ACC), Ed Tuohy, MD (ACC), Mark Schoenfeld, MD (HRS), David Slotwiner, MD (HRS), James Ip, MD (HRS) and Sanjaya Gupta, MD, MBA (ACC)**

In September 2022, the CPT Editorial Panel created 8 new Category I CPT codes to describe insertion, repositioning, removal, and removal and replacement of a phrenic nerve stimulator system. The CPT Editorial Panel added 4 additional new Category I codes to describe activation, interrogation, and programming of a phrenic nerve stimulator system. The new codes will replace 13 Category III codes, 0424T-0436T. The new codes treat moderate to severe Central Sleep Apnea (CSA) for patients with concomitant conditions such as heart failure with reduced ejection fraction and are expected to have low utilization. The 12 new Category I codes were surveyed for the January 2023 RUC meeting.

For these services, a phrenic nerve stimulation system includes a pulse generator, one stimulation lead (electrode), and in some cases a sensing lead. To place a pulse generator, a submuscular or subcutaneous “pocket” is created in the pectoral region. The stimulation lead is placed transvenously into the right brachiocephalic vein or left pericardiophrenic vein. Then, if needed, a sensing lead is placed transvenously into the azygos vein. CPT codes 33276-33288 include vessel catheterization, as well as all image guidance.

Programming of the phrenic nerve stimulator system is typically performed one month after implantation by an electrophysiologist or a sleep medicine physician. CPT codes 93150-93153 are for interrogation and programming device evaluation which include parameters of rate, pulse amplitude, pulse duration, configuration of waveform, battery status, electrode select-ability, output modulation, cycling, impedance, and patient compliance measurements (eg, hours of therapy, sleeping position, and sleep/awake activity). For patients that require programming during an overnight sleep study, 93152 is only reported once, regardless of how many programming changes are made over the course of the sleep study.

Given the low utilization of these services, the specialty societies used a targeted and random survey approach to secure the survey threshold minimum (ie, 30 responses). Despite the efforts to meet the survey minimum, the specialty societies did not receive 30 responses for any codes in the family. The 12 new codes were created to provide comprehensive reporting of the family when needed.

***33276 Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]) including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation when performed***

The RUC reviewed the survey results from 28 electrophysiologists and cardiologists and recommends a work RVU of 9.50 based on the survey 25<sup>th</sup> percentile which appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 6 minutes scrub/dress/wait time, 120 minutes intra-service time, and 25 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99214 office visit, and 253 minutes total time. For this procedure, patients are not under general anesthesia because they must participate during the procedure, therefore, 14 minutes of time for observing anesthesia care was removed as only 1 minute to apply topical anesthetic is needed. The RUC agreed that pre-service package is appropriate given the typical patient is complicated and presents with heart failure with reduced Ejection Fraction and subsequent CSA. Further, the procedure is complex because lead placement is in the brachiocephalic or pericardiophrenic vein and there is risk of vascular or cardiac damage. The specialty societies indicated, and the RUC agreed, that a half-day discharge management and an office visit are typical to ensure the device is implanted properly.

For this procedure, the patient is under moderate sedation and venous access is made in order to place the stimulation lead into the right brachiocephalic or left pericardiophrenic vein. The placement of the lead requires significant caution to not lacerate the surrounding vessels. The stimulation lead is carefully repositioned if needed and then stimulation and impedance characteristics are completed using a phrenic nerve stimulation system analyzer. The patient is aroused and asked for feedback as to how closely the simulation represents a normal breath. The lead is stabilized and connected to the implantable pulse generator. A subcutaneous pocket is created in the pectoral region and the pulse generator is inserted and the incision is closed.

To support the recommended work RVU of 9.50, the RUC compared the surveyed code to key reference service codes 33270 *Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed* (work RVU = 9.10, 39 minutes pre-service, 90 minutes intra-service and 232 minutes total time) and 33208 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular* (work RVU = 8.52, 40 minutes pre-service, 60 minutes intra-service and 231 minutes total time). The reference codes are ideal comparators given that both codes are for the insertion of an implantable device. Given the similar work of the procedures, the surveyed code is valued appropriately due to the higher intra-service time and total time, albeit the lower intensity compared to the reference codes. For additional support, the RUC compared the surveyed code to CPT Code 64581 *Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)* (work RVU= 12.20, intra-service time of 120 minutes, total time of 269 minutes) and noted that both services involve an identical amount of intra-service time, similar total times and the same number and level of post-operative visit codes. Both services describe the insertion of a nerve stimulation device, though the reference code is a more intense procedure to perform, justifying a lower value for the surveyed code.

The RUC concluded that CPT code 33276 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey given the relativity within the code family, even though the survey threshold was not met. **The RUC recommends a work RVU of 9.50 for CPT code 33276.**

***33277 Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 24 electrophysiologists and cardiologists and recommends a work RVU of 5.43 based on the survey 25<sup>th</sup> percentile which maintains relativity within the family. The RUC recommends 120 minutes intra-service and total time for this add-on code.

For this procedure, the patient is undergoing a subcutaneous implantation of a phrenic nerve stimulator system and requires the placement of an additional transvenous sensing lead. The additional sensing lead is carefully positioned into the azygos vein using transvenous implantation techniques. Once placed, the lead is tested using a neurostimulator analyzer to ensure proper function. The lead is stabilized using suture sleeves and connected to the implantable pulse generator.

To support the recommended work RVU of 5.43, the RUC compared the surveyed code to key reference service codes 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU = 8.00, 60 minutes intra-service and total time) and 93609 *Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)* (work RVU = 4.99, 90 minutes intra-service and total time). The codes appropriately bracket the surveyed code work RVU given that the surveyed code has a higher intra-service time and a lower relative intensity when compared to the key reference services.

For additional support, the RUC compared the surveyed code to CPT code 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* (work RVU = 5.23, 90 minutes intra-service and total time). This similar cardiology procedure supports the surveyed code's relativity within the MFS as both services have similar work RVUs, intra-service time, and intensity. **The RUC recommends a work RVU of 5.43 for CPT code 33277.**

***33278 Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)***

The RUC reviewed the survey results from 24 electrophysiologists and cardiologists and recommends a work RVU of 9.55 based on the survey 25<sup>th</sup> percentile, which maintains relativity within the family. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 6 minutes scrub/dress/wait time, 120 minutes intra-service time, and 28 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99213 office visit, and 239 minutes total time. For this procedure, patients do not participate so they are under general anesthesia to mitigate the potential risk of vessel perforation. The RUC determined that the pre-service package was appropriate because the typical patient is complicated and presents with heart failure with reduced ejection fraction and subsequent CSA. Further, removal procedures are exceedingly complex given that lead extraction is in the brachiocephalic or pericardiophrenic vein and there is risk of vascular or cardiac damage. Survey respondents indicated, and the RUC concurred, that a half-day discharge management and an office visit are typical to ensure the removal was successful.



For this procedure, the typical patient includes one lead removal. The patient is under general anesthesia. The implanted pulse generator and lead are carefully freed from surrounding tissue using fluoroscopic guidance. If it is not possible to remove and disconnect the device and lead using fluoroscopic guidance, then standard extraction techniques are used. Once the device and lead can be removed and hemodynamic stability is verified, the incision is closed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 33235 *Removal of transvenous pacemaker electrode(s); dual lead system* (work RVU = 9.90, 50 minutes pre-service, 170 minutes intra-service and 390 minutes total time) and 33234 *Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular* (work RVU = 7.66, 50 minutes pre-service, 150 minutes intra-service and 292 minutes total time). The reference codes are ideal comparators given that both codes are for the removal of an implantable device with leads. Given the similar work of the procedures, the surveyed code is valued appropriately due the higher overall intensity to remove a phrenic nerve stimulator, albeit the lower intra-service and total time compared the reference codes. **The RUC recommends a work RVU of 9.55 for CPT code 33278.**

***33279 Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only***

The RUC reviewed the survey results from 24 electrophysiologists and cardiologists and recommends a work RVU of 5.42 based on a crosswalk to CPT code 33272 *Removal of subcutaneous implantable defibrillator electrode* (work RVU = 5.42, 39 minutes pre-service, 45 minutes intra-service time, and 151 minutes total time) which maintains relativity within the family. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 6 minutes scrub/dress/wait time, 120 minutes intra-service time, and 28 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99213 office visit, and 239 minutes total time. For this procedure, patients do not participate so they are under general anesthesia to mitigate the potential risk of vessel perforation. The RUC determined that the pre-service package is appropriate because the typical patient is complicated and presents with heart failure with reduced ejection fraction and subsequent CSA. Further, removal procedures are exceedingly complex given that lead extraction is in the azygos vein and there is risk of vascular or cardiac damage. The typical patient refers to the removal of the stimulation lead. Survey respondents indicated, and the RUC concurred, that a half-day discharge management and an office visit are typical to ensure the removal was successful.

This is a unique code within the family and is expected to be rarely performed. The rarity is due to the procedure only being performed in instances when only the lead requires extraction. For this lead only removal procedure, the patient is under general anesthesia. The lead is carefully freed from the surrounding tissue using fluoroscopic guidance. If it is not possible to remove the lead using fluoroscopic guidance, then standard extraction techniques are used. Once the lead can be removed and hemodynamic stability is verified, the incision is closed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 33234 *Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular* (work RVU = 7.66, 50 minutes pre-service, 150 minutes intra-service and 292 minutes total time) and 33235 *Removal of transvenous pacemaker electrode(s); dual lead system* (work RVU = 9.90, 50 minutes pre-service, 170 minutes intra-service and 390 minutes total time). The reference codes are ideal comparators given that both codes are for the removal of an implantable device lead system. Given the similar work of the procedures, the surveyed code is valued appropriately since it requires less intra-service and total time. Although, the intensity of the work involved in the surveyed code is similar to that of the key reference services supporting the recommended work RVU.

Additionally, the surveyed code is valued appropriately lower than family code 33278 given the lower intensity to only remove one lead. The RUC concluded that CPT code 33279 should be valued based on a direct work RVU crosswalk to CPT code 33272 and agreed the crosswalk value below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 5.42 for CPT code 33279.**

***33280 Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only***

The RUC reviewed the survey results from 24 electrophysiologists and cardiologists and recommends a work RVU of 3.04 based on a crosswalk to CPT code 33241 *Removal of implantable defibrillator pulse generator only* (work RVU = 3.04, 35 minutes pre-service, 60 minutes intra-service, and 171 minutes total time) which maintains relativity within the family. The RUC recommends 18 minutes of pre-service evaluation time, 1 minute positioning time, 6 minutes scrub/dress/wait time, 60 minutes intra-service time, and 28 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99213 office visit, and 155 minutes total time. For this procedure, patients do not participate so they are under general anesthesia to mitigate the potential risk of vessel perforation. The RUC determined that the pre-service package is appropriate because the typical patient is complicated and presents with heart failure with reduced ejection fraction and subsequent CSA. Further, removal of the pulse generator is somewhat more straightforward than lead extraction making this procedure less complicated than others in the code family. Survey respondents indicated, and the RUC concurred, that a half-day discharge management and an office visit are typical to ensure the removal was successful.

This is a unique code within the family as it is expected to be rarely performed. The rarity is due to the procedure only being performed in instances when the currently implanted lead could not be removed at the same time as the pulse generator. For this pulse generator removal only procedure, the patient is under general anesthesia. The pulse generator is carefully freed from the surrounding tissue. Once the device is able to be removed and hemodynamic stability is verified, the incision is closed.

To support the recommended work RVU of 3.04, the RUC compared the surveyed code to key reference service codes 33223 *Relocation of skin pocket for implantable defibrillator* (work RVU = 6.30, 48 minutes pre-service, 90 minutes intra-service and 230 minutes total time) and 33218 *Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator* (work RVU = 5.82, 50 minutes pre-service, 90 minutes intra-service and 246 minutes total time). The reference codes are ideal comparators since both codes are for the relocation and repair of an implantable device. Given the similar work of the procedures, the surveyed code is valued appropriately lower than the reference codes due to the lower intra-service time, total time, and relative intensity. The RUC concluded that CPT code 33280 should be valued based on a direct work RVU crosswalk to CPT code 33241 and agreed the crosswalk value below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 3.04 for CPT code 33280.**

***33281 Repositioning of phrenic nerve stimulator transvenous lead(s)***

The RUC reviewed the survey results from 25 electrophysiologists and cardiologists and recommends a work RVU of 6.00 based on the survey 25<sup>th</sup> percentile which maintains relativity within the family. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 6 minutes scrub/dress/wait time, 110 minutes intra-service time, and 28 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99214 office visit, and 246 minutes total time. For this procedure, patients are not under general anesthesia because they must participate during the procedure, therefore, 14 minutes of time for observing anesthesia care was removed as only 1 minute to apply topical anesthetic is needed. The RUC determined that the pre-service package is appropriate because the typical patient is complicated and presents with heart failure with reduced ejection fraction and

subsequent CSA. Further, repositioning leads are exceedingly complex given that lead manipulation is in the brachiocephalic or pericardiophrenic vein and the subsequent surrounding cardiac tissue is delicate. Survey respondents indicated, and the RUC concurred, that a half-day discharge management and an office visit are typical to ensure the repositioning was successful.

For this repositioning procedure, the patient is under moderate sedation. The implanted pulse generator and lead are disconnected, and the lead is freed from the surrounding tissue using fluoroscopic guidance. If it is not possible to free and disconnect the lead from the implanted pulse generator using fluoroscopic guidance, then standard extraction techniques are used. The original lead is repositioned to a more satisfactory location within the left pericardiophrenic or the right brachiocephalic vein and analyzed. The patient is aroused and asked for feedback as to how closely the simulation represents a normal breath. Once the lead is repositioned, re-connected to the pulse generator, and hemodynamic stability is verified, the incision is closed.

To support the recommended work RVU of 6.00, the RUC compared the surveyed code to key reference service codes 33215 *Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode* (work RVU = 4.92, 20 minutes pre-service, 60 minutes intra-service and 179 minutes total time) and 33208 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular* (work RVU = 8.52, 40 minutes pre-service, 60 minutes intra-service and 231 minutes total time). The reference codes are ideal comparators given that both codes are for the replacement and/or repositioning of an implantable device. Given the similar work of the procedures, the surveyed code is valued appropriately due to the significantly higher intra-service time and total time, albeit the low intensity compared to the reference codes. **The RUC recommends a work RVU of 6.00 for CPT code 33281.**

***33287 Removal and replacement of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming when performed; pulse generator***

The RUC reviewed the survey results from 26 electrophysiologists and cardiologists and recommends a work RVU of 6.05 based on the survey 25<sup>th</sup> percentile which maintains relativity within the family. The RUC recommends 18 minutes of pre-service evaluation time, 1 minute positioning time, 6 minutes scrub/dress/wait time, 70 minutes intra-service time, and 23 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99214 office visit, and 177 minutes total time. For this procedure, patients are not under general anesthesia because they may participate during the procedure. The RUC determined that the pre-service package is appropriate because the typical patient is complicated and presents with heart failure with reduced ejection fraction and subsequent CSA. Further, removal and replacement of the pulse generator is somewhat more straightforward than lead extraction making this procedure less complicated than others in the code family. Survey respondents indicated, and the RUC concurred, that a same day discharge and an office visit are typical to ensure the removal and replacement was successful.

For this pulse generator only removal and replacement service, the patient is under moderate sedation. The pulse generator is carefully freed from the surrounding tissue. Once the device is removed, the pocket is assessed, and a new pulse generator is implanted. The leads are reconnected, hemodynamic stability is verified, and the incision is closed.

To support the recommended work RVU of 6.05, the RUC compared the surveyed code to key references codes 33223 *Relocation of skin pocket for implantable defibrillator* (work RVU = 6.30, 48 minutes pre-service, 90 minutes intra-service and 230 minutes total time) and 33218 *Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator* (work RVU = 5.82, 50 minutes pre-service, 90 minutes intra-service and 246 minutes total time). The reference codes are

ideal comparators given that both codes are for the relocation and repair of an implantable device. Given the similar work of the procedures, the surveyed code is valued appropriately between the reference codes due to the lower intra-service time, total time, and higher relative intensity. For additional support, the RUC compared the surveyed code to MPC code 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 7.80, 60 minutes intra-service, 234 minutes total time). The surveyed code is valued appropriately lower when compared to the MPC code given the lower total time and intensity, albeit the slightly higher intra-service time. **The RUC recommends a work RVU of 6.05 for CPT code 33287.**

**33288 Removal and replacement of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming when performed; transvenous stimulation or sensing lead**

The RUC reviewed the survey results from 24 electrophysiologists and cardiologists and recommends a work RVU of 8.51 based on the survey 25<sup>th</sup> percentile which maintains relativity within the family. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 6 minutes scrub/dress/wait time, 120 minutes intra-service time, and 28 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99214 office visit, and 246 minutes total time. For this procedure, patients are not under general anesthesia because they must participate during the procedure, therefore, 14 minutes of time for observing anesthesia care was removed as only 1 minute to apply topical anesthetic is needed. The RUC determined that the pre-service package is appropriate because the typical patient is complicated and presents with heart failure with reduced ejection fraction and subsequent CSA. Further, removal and repositioning leads are exceedingly complex given that lead manipulation is in the brachiocephalic or pericardiophrenic vein and the subsequent surrounding cardiac tissue is delicate. Survey respondents indicated, and the RUC concurred, that a half-day discharge management and an office visit are typical to ensure the removal and replacement was successful.

For this lead only removal and replacement procedure, the patient is under moderate sedation. The lead is carefully freed from the surrounding tissue using fluoroscopic guidance. If it is not possible to remove and disconnect the lead from the implanted pulse generator using fluoroscopic guidance, then standard extraction techniques are used. The lead is then carefully removed, and replacement with a new lead begins. The replacement of the lead requires significant caution as to not lacerate the surrounding vessels. The stimulation lead is carefully repositioned if needed and then stimulation and impedance characteristics are completed using a phrenic nerve stimulation system analyzer. The patient is aroused and asked for feedback as to how closely the simulation represents a normal breath. The lead is stabilized and connected to the implantable pulse generator. Once hemodynamic stability is verified, the incision is closed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 33235 *Removal of transvenous pacemaker electrode(s); dual lead system* (work RVU = 9.90, 50 minutes pre-service, 170 minutes intra-service and 390 minutes total time) and 61886 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays* (work RVU = 9.93, 50 minutes pre-service, 100 minutes intra-service and 385 minutes total time). The reference codes are ideal comparators since both codes are for the removal and insertion of an implantable device with leads. **The RUC recommends a work RVU of 8.51 for CPT code 33288.**

**93150 Therapy activation of implanted phrenic nerve stimulator system including all interrogation and programming**

The RUC reviewed the survey results from 21 electrophysiologists and recommends a work RVU of 0.85 based on the survey 25<sup>th</sup> percentile which maintains relativity within the interrogation and

programming family. The RUC recommends 10 minutes of pre-service evaluation time, 20 minutes intra-service time, 8 minutes immediate post-service time, and 38 minutes total time.

For this service, the phrenic nerve stimulator system is programmed for the first time post implantation. During implantation, the device is turned on and captures data for approximately 30 days until the initial programming visit. Evaluation parameters include respiratory rate, pulse amplitude, pulse duration, selection of sensing vector, battery status, electrode selection, timing of stimulation impedance, and patient compliance measurements for the implanted lead(s). The parameters are used to configure the initial settings and the patient is educated about interaction with the system. Any concomitant devices are paired, and all stimulation settings are evaluated for accuracy.

To support the recommended work RVU of 0.85, the RUC compared the surveyed code to top key references code 93281 *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; multiple lead pacemaker system* (work RVU = 0.85, 15 minutes intra-service and 32 minutes total time). Key reference service 93281 is an ideal comparison given that it is also for programming of an implanted device. The surveyed code is similarly valued due to the higher intra-service and total time, albeit lower intensity to perform the service.

For additional support, the RUC compared the surveyed code to MPC code 95971 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RUV = 0.78, 20 minutes intra-service and 33 minutes total time) and noted that both services have identical intra-service time, whereas the survey code typically involves 5 more minutes of total time. **The RUC recommends a work RVU of 0.85 for CPT code 93150.**

**93151 Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system**

The RUC reviewed the survey results from 20 electrophysiologists and recommends a work RVU of 0.80 based on the survey 25<sup>th</sup> percentile, which maintains relativity within the interrogation and programming family. The RUC recommends 10 minutes of pre-service evaluation time, 20 minutes intra-service time, 6 minutes immediate post-service time, and 36 minutes total time.

For this service, the phrenic nerve stimulator system has previously undergone device programming. The device is evaluated for the following parameters: respiratory rate, pulse amplitude, pulse duration, selection of sensing vector, battery status, electrode selection, timing of stimulation impedance, and patient compliance measurements for the implanted lead(s). Based on the data and patient input, at least one of the parameters is adjusted for optimal device results.

To support the recommended work RVU of 0.80, the RUC compared the surveyed code to key reference codes 93280 *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 pacemaker system* (work RVU = 0.77, 15 minutes intra-service and 32 minutes total time) and 93281 *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; multiple lead pacemaker system* (work RVU = 0.85, 15 minutes intra-service and 32 minutes total time). These codes are optimal comparators given that they are both for the programming of an implanted device. The surveyed code work RVU is appropriately bracketed by the key reference services as it has higher intra-service and total time, although relatively lower intensity to perform the service.

For additional support, the RUC compared the surveyed code to MPC codes 95971 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RUV = 0.78, 20 minutes intra-service and 33 minutes total time) and noted that both services have similar intra-service time and similar total time, supporting the surveyed code work RVU of 0.80. **The RUC recommends a work RVU of 0.80 for CPT code 93151.**

### ***93152 Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography***

The RUC reviewed the survey results from 19 electrophysiologists and recommends a work RVU of 1.82 based on a crosswalk to CPT code 71275 (work RVU = 1.82, 25 minutes intra-service and 35 minutes total time) which maintains relativity within the interrogation and programming family. The RUC recommends 10 minutes of pre-service evaluation time, 25 minutes intra-service time, 10 minutes immediate post-service time, and 45 minutes total time.

For this service, the phrenic nerve stimulator system has previously undergone device programming. This service is typically reported during polysomnography (ie, sleep study) to optimize the device for the patient. The service is only reported once for the entire sleep study. During the study, continuous evaluation is performed to change parameters (ie, respiratory rate, pulse amplitude, pulse duration, and patient arousal) based on the findings. The settings are then adjusted with the patient laying in three different positions and then one final programming adjustment is made to the device to improve performance. This service gathers a much larger amount of data to be interpreted and is therefore more intense and complex than the interrogation and programming codes in this family.

To support the recommended work RVU of 1.82, the RUC compared the surveyed code to MPC codes 92005 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.82, 25 minutes intra-service and 40 minutes total time) and 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU = 2.01, 30 minutes intra-service and 40 minutes total time). The surveyed code is valued appropriately when compared to MPC code 92005 given that the intra-service time is identical, and the surveyed code has similar intensity. When compared to MPC code 74178, the surveyed code is valued appropriately lower given the lower intra-service time and relative intensity. The RUC concluded that CPT code 93152 should be valued based on a direct work RVU crosswalk to CPT code 71275 and agreed the crosswalk value below the survey 25<sup>th</sup> percentile was appropriate. **The RUC recommends a work RVU of 1.82 for CPT code 93152.**

**93153 Interrogation, without programming, of implanted phrenic nerve stimulator system**

The RUC reviewed the survey results from 20 electrophysiologists and recommends a work RVU of 0.43 based on a crosswalk to CPT code 93288 *Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system* (work RVU = 0.43, 10 minutes intra-service and 22 minutes total time). The crosswalk is a similar service to the surveyed code and maintains relativity within the interrogation and programming family. The RUC recommends 7 minutes of pre-service evaluation time, 13 minutes intra-service time, 5 minutes immediate post-service time, and 25 minutes total time.

For this service, the phrenic nerve stimulator system has previously undergone device programming. The device is interrogated to evaluate the following parameters: respiratory rate, pulse amplitude, pulse duration, selection of sensing vector, battery status, electrode selection, timing of stimulation impedance, and patient compliance measurements for the implanted lead(s). Based on the findings, none of the parameters are adjusted.

To support the recommended work RVU the RUC compared the surveyed code to top key references code 93280 *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 pacemaker system* (work RVU = 0.77, 15 minutes intra-service and 32 minutes total time). The surveyed code is valued appropriately lower than the key reference services given the lower intra-service time, total time, and intensity.

For additional support, the RUC compared the surveyed code to CPT code 93924 *Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study* (work RVU = 0.50, 13 minutes intra-service and 20 minutes total time). The surveyed code is valued appropriately lower when compared to code 93924 given that they have similar times, however, the surveyed code is significantly less intense to perform. The RUC concluded that CPT code 93153 should be valued based on a direct work RVU crosswalk to CPT code 93288 and agreed the crosswalk value below the survey 25<sup>th</sup> percentile was appropriate. **The RUC recommends a work RVU of 0.43 for CPT code 93153.**

**Practice Expense**

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made several modifications. For the 090-global codes, the supply input SA048 *pack, minimum multi-specialty visit* was reduced to one for codes 33278 and 33279 as there is now only one post-operative visit not two, and SA054, *pack, post-op incision care (suture)* was removed for all the codes in the series as it is not typical for the removal codes. Additionally, the equipment input EF031 *table, power* was switched to EF023 *table, exam*.

For the XXX-global interrogation and programming codes, the pre-service times were adjusted to add 3 minutes for CA011, *provide education/obtain consent* to CPT codes 93150, 93151, and 93153. For CPT code 93152, it was noted that the code is duplicative of the sleep study so SA048 *pack, minimum multi-specialty visit* and the minutes for EF023 *table, exam* were removed. Further, a new equipment

item, *phrenic nerve stimulator programmer with wand*, was added to each code respectively. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

#### **New Technology**

CPT codes 33276, 33277, 33278, 33279, 33280, 33281, 33287, 33288, 93150, 93151, 93152, and 93153 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

#### **RUC Database Flag**

The RUC and specialty societies agreed that CPT codes 33276, 33277, 33278, 33279, 33280, 33281, 33287, 33288, 93150, 93151, 93152, and 93153 should be marked as “Do not use to validate physician work” in the RUC database given the low survey responses.

#### **RAW Flag**

The RUC recommends flagging CPT codes 33276, 33277, 33278, 33279, 33280, 33281, 33287, 33288, 93150, 93151, 93152 and 93153 since the survey responses were below 30. These services will be reviewed by the Relativity Assessment Workgroup in three years. At that time the specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.

#### **Posterior Nasal Nerve Ablation (Tab 7)**

##### **R. Peter Manes, MD (AAO-HNS) and Ari Wirtschafter, MD (AAO-HNS)**

In January 2021, HCPCS code C9771 *Nasal Endoscopy with Cryoablation of nasal tissue and/or nerves* was implemented by CMS through the new technology application process. The code reports the first energy-based ablation technology FDA cleared for this type of procedure for tracking purposes. In September 2022, the CPT Editorial Panel created two separate codes, 31242 and 31243, one to describe radiofrequency ablation and one to describe cryoablation of the posterior nasal nerve. In preparation for the January 2023 RUC meeting, both new posterior nasal nerve codes, as well as family codes 30117 and 30118, were surveyed. Survey respondents were from a random sample of American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) members who self-designate as a general otolaryngologist or rhinologist in the specialty’s member database.

During their presentation to the Research Subcommittee, the specialty noted that the services described by 31242 and 31243 were formerly often miscoded. CPT code 30117 was incorrectly used for reporting these posterior nerve ablation procedures, though the description of physician work is clinically different, and the typical patient is unlike those suffering from chronic rhinitis who receive an energy-based treatment. In addition, the unlisted code that should have been used to report the work described by codes 31242 and 31243; 30999 *Unlisted procedure, nose*, lacks specificity regarding patient selection criteria, physician work, and equipment required to perform the procedure.

Posterior Nasal Nerve (PNN) ablation is an endoscopic procedure that utilizes energy-based neurolysis to treat chronic rhinitis. The operative use of cryoablation or radiofrequency energy is intended to ablate an overactive posterior nasal nerve and induce denervation of the nasal mucosa and relieve sensory nasal symptoms. The surgical procedure itself is minimally invasive and the emerging energy-based devices in use have been cleared by the FDA in recent years with the specific indication to use for this type of treatment.



**30117 Excision or destruction (eg, laser), intranasal lesion; internal approach**

The RUC reviewed the survey results from 97 otolaryngologists and determined that the survey 25<sup>th</sup> percentile work RVU of 3.91 accounts for typical physician work required to perform this service. The RUC recommends 20 minutes pre-service evaluation time, 3 minutes pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 30 minutes intra-service time and 10 minutes post-service time as supported by the survey, as well as 05.-99238 discharge visit and 2-99213 post-operative visits, equaling 133 minutes of total time.

The specialty society selected pre-service time package *3-FAC Straightforward Patient/Difficult Procedure* and post-service time package *9A General Anes or Complex Blk/Strghtfrow Proc* since currently this procedure is predominantly performed in the facility setting using general anesthesia. It is notable that both standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. Regarding pre-service care, the RUC agrees with 13 fewer minutes of pre-service evaluation time (decreasing from 33 to 20 minutes) and 10 fewer minutes of pre-service scrub/dress/wait time (decreasing from 15 to 5 minutes). Regarding post-service care, the RUC agrees with 20 fewer minutes of immediate post-service time (decreasing from 30 to 10 minutes).

The intra-service work for CPT code 30117 includes the excision or destruction of an intranasal lesion by way of an internal approach. With the use of local anesthesia, a laser fiber is inserted into the nasal cavity and laser energy is applied in a circumferential area surrounding the lesion in order to cut off blood supply to the lesion until it has been directly ablated.

Regarding post-operative care, the RUC agrees with the inclusion of 0.5-99238 discharge visit and 2-99213 office visits to perform the necessary post-operative care within the 090-day global period. In their recommendation, the specialty society emphasized the importance of the two subsequent office visits and provided a clear explanation in their description of post-service work. The first post-operative visit will include a comprehensive evaluation of the patient's recovery from surgery, wherein the nose will be decongested by anesthetizing with topical oxymetazoline and lidocaine and clearing the nasal cavity. Additionally, there will be extensive discussion emphasizing nasal irrigation and the importance of avoiding nose-blowing. The second post-operative visit will be a continuation of the work involved with the first visit, but the patient's advanced wound healing will be further evaluated to determine the ability to resume normal activity.

To support the RUC recommended work RVU, the RUC compared CPT code 30117 to the top key reference service code 21555 *Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm* (work RVU = 3.96, 35 minutes intra-service time and 138 minutes of total time) and the second highest key reference service 21011 *Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm* (work RVU = 2.99, 30 minutes intra-service time and 107 minutes total time). The RUC recognizes that the surveyed code closely aligns with codes 21555 and 21011 in terms of intra-service time and total time and the survey 25<sup>th</sup> percentile work RVU of 3.91 maintains relativity within the code family and the Medicare Physician Payment Schedule (MFS). For additional support, the specialty also referenced CPT code 65785 *Implantation of intrastromal corneal ring segments* (work RVU = 5.39, 30 minutes intra-service time, 134 minutes total time) in their recommendation. The RUC notes this 090-day global code is an appropriate clinical comparator to the surveyed code in terms of intraoperative intensity and total time of service. The RUC concluded that CPT code 30117 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.91 for CPT code 30117.**

**30118 Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)**

The RUC reviewed the survey results from 49 otolaryngologists and determined that the median work RVU of 9.55 appropriately accounts for typical physician work required to perform this service. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time and 20 minutes post-service time as supported by the survey, 0.5-99238 discharge visit and 3-99213 post-operative visits, equaling 211 minutes of total time.

The specialty society selected pre-service time package *4 FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc* since currently this procedure is predominantly performed in the facility setting using general anesthesia. The standard time packages were decreased to align with the times as indicated by the survey respondents.

CPT code 30118 requires an intra-service twice as long as 30117 and requires a higher level of clinical complexity and intraoperative intensity. While both procedures conduct the excision or destruction of an intranasal lesion, 30117 involves an internal approach while 30118 involves an external approach. A lateral rhinotomy incision is made extending along the nasofrontal sulcus and once the lower edge of the frontal process of the maxilla is reached, the incision is extended into the nasal cavity. After the lateral nasal and angular vessels, branches of the external maxillary artery and tributaries of the anterior facial vein are identified above and below and ligated, the lateral attachment of the ala nasi is completely mobilized by carrying the incision into the floor of the nose. The nasal flap is then rotated accordingly to allow for adequate visualization of the tumor. Once identified, the entire tumor is completely resected, with special attention to the site of attachment, the wound is irrigated, and the incision is fully closed. The RUC confers that the description of work for 30118 compared to 30117 denotes a greater complexity and intensity of physician work.

Regarding post-operative visits, the first post-operative visit will include a comprehensive evaluation of the patient's recovery from surgery, wherein the surgical wounds are evaluated for any evidence of infection or dehiscence, the facial sutures are removed, steri-strips are applied, a cranial nerve exam is performed and there is extensive discussion emphasizing nasal irrigation and the importance of avoiding nose-blowing. The second post-operative visit will be a continuation of the work involved with the first visit, but the patient's advanced healing will be further evaluated based on scar tissue formation and medication management. The third post-operative visit will serve as a final check-in to assess overall healing, function, aesthetic and potential resumption of normal activity.

To justify a value of 9.55, the RUC compared CPT code 30118 to the top key reference service code 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU = 11.19, 90 minutes intra-service time and 267 minutes of total time) and the second highest key reference service 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03, 60 minutes intra-service time and 201 minutes total time). The RUC recognizes that the surveyed code is appropriately comparable to CPT codes 60220 and 43180 in terms of physician time, work and intraoperative complexity. For additional support, the specialty also referenced 30118 to MPC codes 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible* (work RVU = 10.03, 90 minutes intra-service time and 283 minutes total time) and 21015 *Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm* (work RVU = 9.89, 75 minutes intra-service time and 277 minutes total time) in their recommendation. The RUC notes that together these two 090-day global codes are appropriate clinical comparators to the survey code in terms of intraoperative intensity and total time of service. The RUC concluded that CPT code 30118 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 9.55 for CPT code 30118.**

**31242 Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve**

The RUC reviewed the survey results from 138 otolaryngologists and determined that the survey 25<sup>th</sup> percentile work RVU of 2.70 appropriately accounts for typical physician work required to perform this service. The RUC recommends 17 minutes pre-service evaluation time, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 18 minutes intra-service time and 10 minutes post-service time as supported by the survey, equaling 51 minutes of total time.

The intra-service work for CPT code 31242 includes surgical nasal endoscopy and destruction of the posterior nasal nerve by radiofrequency ablation. Using endoscopic visualization, local anesthesia is administered before the radiofrequency energy delivery device is introduced into the nasal cavity. Multiple applications of radiofrequency are performed around the posterior nasal nerve before the device is withdrawn. This intra-service work is then repeated and performed on the contralateral side.

To justify a value of 2.70, the RUC compared CPT code 31242 to the top key reference service 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 of total time) and the second highest key reference service 31297 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium* (work RVU = 2.44, 20 minutes intra-service time and 56 minutes total time). The RUC recognizes that the surveyed code requires the same physician work at 2.70 work RVUs, almost identical intra-service time and similar intensity and complexity to perform. For further support, the RUC referenced MPC codes 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70, 20 minutes intra-service time and 60 minutes total time) and 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU = 1.73, 20 minutes intra-service time and 59 minutes total time), as well as CPT code 45346 *Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)* (work RVU = 2.81, 20 minutes intra-service time, 53 minutes total time). The RUC notes that together these additional codes provide strong points of comparison in terms of physician work and time, support the survey 25<sup>th</sup> percentile and maintain relativity within the code family. **The RUC recommends a work RVU of 2.70 for CPT code 31242.**

**31243 Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve**

The RUC reviewed the survey results from 153 otolaryngologists and determined that the survey 25<sup>th</sup> percentile work RVU of 2.70 appropriately accounts for typical physician work required to perform this service. The RUC recommends 17 minutes pre-service evaluation time, 1-minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 20 minutes intra-service time and 10 minutes post-service time as supported by the survey, equaling 53 minutes of total time.

The description of intra-service work for CPT code 31243 details surgical nasal endoscopy and destruction of the posterior nasal nerve by way of cryoablation. Performed using endoscopic visualization, local anesthesia is administered using pledgets soaked in decongestant before an intranasal anesthetic/vasoconstrictive agent is injected into the lateral attachment to medialize the middle turbinate. The cryoablation probe is then introduced into the nasal cavity and cryotherapy freezing is then performed under scrupulous endoscopic observation. Once the freezing process is complete, the patient is asked to breathe through their nose while the cryotherapy probe unfreezes from the affected mucosa. The probe is then withdrawn and pledgets soaked in decongestant are then placed in the treated areas to allow for hemostasis. This intra-service work is then repeated and performed on the contralateral side.

The additional two minutes of intra-service time for 31243 when compared to 31242 can be accounted for due to the difference in technology being used. During cryoablation, when the wand is removed from the nose after completing the first side, the cryotherapy container needs to be removed from the wand and replaced with a second canister in order to complete the other (contralateral) side. While this low intensity activity accounts for the additional time, the activity does not represent a change in the intensity of physician work. To justify a value of 2.70, the RUC compared CPT code 31243 to the top key reference service 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 of total time) and the second highest key reference service code 30140 *Submucous resection inferior turbinate, partial or complete, any method* (work RVU = 3.00, 20 minutes intra-service time and 78 minutes total time). The RUC recognizes that the surveyed code aligns closely with 31295 and 30140 in terms of intra-service time, total time and intraoperative intensity and further notes that the recommended work RVU of 2.70 exactly matches the top key reference service code. For further support, the RUC referenced MPC codes 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70, 20 minutes intra-service time and 60 minutes total time) and 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU = 1.73, 20 minutes intra-service time and 59 minutes total time) and CPT code 31572 *Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral* (work RVU = 3.01, 20 minutes intra-service time, 60 minutes total time). The RUC notes that together these additional codes provide strong points of comparison in terms of physician work and time, support the survey 25<sup>th</sup> percentile and maintain relativity within the code family. **The RUC recommends a work RVU of 2.70 for CPT code 31243.**

### **Practice Expense**

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee considered and approved compelling evidence based upon changes in supplies and equipment due to change in technique. The Subcommittee discussed the two new high-cost supply items, *radiofrequency stylus/wand* and *cryoablation handpiece and two canisters*, as well as the new equipment input, *radiofrequency console*. It restated continued support for the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies using separate and appropriate HCPCS codes.

The PE Subcommittee noted the additional 3 minutes for CA037 *Conduct patient communications* in CPT codes 30117 and 30118. The specialty society indicated that this call to a patient is typical 1-2 days post-op. The Subcommittee recognized that a phone call is outside of the 090-day global standard but agreed that this type of post-operative communication is evolving and reflects best practice. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

### **CPT Assistant Article**

The RUC will recommend to CPT that a CPT Assistant article be created for CPT code 30117 to address the number of typical units of service performed on the same date which should be 1 moving forward not 2, and to also address possible inappropriate coding.

### **New Technology**

CPT codes 31242 and 31243 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

### **Work Neutrality**

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

### **Cystourethroscopy with Urethral Therapeutic Drug Delivery (Tab 8)**

**Thomas Turk, MD (AUA), Jonathan Kiechle, MD (AUA) Jyoti Chouhan, MD (AUA) and Drew Peterson, MD (AUA)**

In September 2022, the CPT Editorial Panel replaced Category III code 0499T with the new Category I CPT code 52284 to describe cystourethroscopy with mechanical urethral dilation and urethral therapeutic drug delivery.

### ***52284 Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed***

The RUC reviewed the survey results from 119 urologists and determined that the survey 25<sup>th</sup> percentile work RVU of 3.10 appropriately accounts for the physician work required to perform this service. The RUC recommends 25 minutes pre-service evaluation, 5 minutes positioning, 6 minutes scrub/dress/wait time, 20 minutes intra-service time and 15 minutes immediate post-service time. This service is typically performed under general anesthesia in the facility setting.

The specialties noted that CPT code 52284 requires a retrograde urethrogram to appropriately measure the length of stricture along with an initial pre-dilation to ensure that the stricture can be successfully dilated prior to placement of the drug-coated balloon. It was noted that the retrograde urethrogram is bundled into 52284 and not separately reported.

In order to perform the bundled retrograde urethrogram, the patient is placed in the lateral decubitus position. Following that initial imaging, the patient is switched to the dorsal lithotomy position. Following measurement and pre-dilation using a balloon catheter, a separate drug-coated balloon is then placed and kept inflated for a minimum of 5 minutes. Fluoroscopy is used throughout the procedure to confirm appropriate balloon placement. These initial steps are required to confirm that both the stricture can be dilated and that the balloon is in the correct placement with a small overlap of the healthy urethra on either side. If any portion of the stricture is not covered by the drug-coated balloon, then the long-term recurrence rate of a stricture will be significantly higher. In clinical trial studies, it was shown that if the initial steps are not performed then the device will not be successful.

To justify a work RVU of 3.10, the RUC referenced MPC and 2<sup>nd</sup> key reference code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU= 3.20, 21 minutes of intra-service time, 58 minutes of total time), and noted that both cystourethroscopy require almost identical intra-service time and typically a similar amount of physician work. The RUC also compared the surveyed code to top key reference code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU= 4.00, intra-service time of 25 minutes, total time of 81 minutes) and noted that the reference code involves 5 more minutes of intra-service time and 10 more minutes of total time. The RUC noted that a work value of 3.10 for the surveyed code would have appropriate relativity with reference code 52441.

For additional support, the RUC noted that MPC code 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU= 2.75, intra-service time of 20 minutes, total time of 46 minutes) has identical intra-service time, however, involves less physician work and much less total time. The specialty noted that reference code 52281 requires less physician work as it only

involves a single balloon dilation, whereas the surveyed code involves two balloon dilations. CPT code 52284 is an intense service as the typical patient would have had prior dilations and significant scarring in the urethra and more than three prior endoscopic procedures. The RUC concluded that CPT code 52284 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.10 for CPT code 52284.**

### **Practice Expense**

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made modifications to the clinical staff time and supplies. The Subcommittee revised CA002 *Coordinate pre-surgery services (including test results)* to 3 minutes in the non-facility setting to align with the Use of Clinical Staff for Endoscopy standards, and added the standard 2 minutes for CA031 *Review examination with interpreting MD/DO* and 1 minute for CA032 *Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue* for imaging services. The PE Subcommittee reduced the supply input SH048 *lidocaine 2% jelly, topical (Xylocaine)* to 20 ml and removed SH069 *sodium chloride 0.9% irrigation (500-1000ml uou)* to eliminate any duplication with items included in the packs and trays. **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 52284 be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

### **CPT Referral**

During the PE Subcommittee discussion, a PE Subcommittee member noted that the CPT *Do Not Report* parenthetical only listed the interpretation and report CPT code for retrograde urethrogram (74450 *Urethrocytography, retrograde, radiological supervision and interpretation*) instead of also listing the separate injection code (51610 *Injection procedure for retrograde urethrocytography*). As the surveyed code 52284 bundles the work of a retrograde urethrogram, it was unclear if the omission of 51610 was an oversight or if that bundling is inherent for a large group of services. **The RUC recommends that CPT code 52284 be referred to the CPT Editorial Panel to determine whether the parenthetical should be revised to “(Do not report 52284 in conjunction with 51610, 52000, 52281, 52283, 74450, 76000)” to clarify that the work of 51610 is bundled into CPT code 52284.** *Note, the CPT Editorial Panel made the parenthetical change, as was proposed by the RUC, on February 3, 2022.*

### **Transcervical RF Ablation of Uterine Fibroids (Tab 9)**

**Jon Hathaway, MD (ACOG), Mitch Schuster, MD (ACOG) and Eileen Attwood, MD (ACOG)**

In September 2022, the CPT Editorial Panel replaced Category III code 0404T with the new Category I CPT code 58580 to describe transcervical radiofrequency ablation of uterine fibroid(s).

### ***58580 Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency***

The RUC reviewed the survey results from 45 obstetricians/gynecologists and determined that the survey 25<sup>th</sup> percentile work RVU of 7.21 appropriately accounts for the work involved in this service. The RUC recommends 33 minutes pre-service evaluation, 8 minutes positioning, 10 minutes scrub/dress/wait time, 45 minutes intra-service time and 15 minutes immediate post-service time, ½ day discharge (99238) and 1x 99213 post-operative office visit. This service is typically performed under general anesthesia in the facility setting. CPT code 58580 is a relatively intense service to perform, with risks of perforating the fibroid, endometrium, myometrium, bladder and bowel. There is also a risk of hemorrhage and cramping in the uterine muscle layer.

To justify a work RVU of 7.21, the RUC referenced top key reference code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed* (work RVU= 6.41, intra-service time of 45 minutes, total time of 167 minutes) and noted that although both services involve identical intra-service time, the majority of survey respondents that selected this key reference code indicated the surveyed code was a more intense and complex service to perform (94 percent). Reference service code 58356 describes a procedure that only involves placing a blunt probe that is 5 mm through the cervix and into the endometrial cavity without perforating any surrounding anatomy. Further, the reference code does not require the use of any sharp instruments, lowering the patient risk. The surveyed code is a much more intense and complex procedure that requires cervical dilation to 9 mm. Following dilation, the surgeon places a trocar through that 9 mm dilated cervix into the endometrial layer and into the fibroid. Then, the surgeon inserts sharp metal tines into the fibroid to achieve the RF ablation. The RUC concurred with the specialty's assertion that the surveyed code is a much more intense service to perform. It was noted that the greater dilation of the cervix (9 mm vs 5 mm) also adds additional risk to the procedure.

The RUC also compared the surveyed code to CPT code 22514 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar* (work RVU= 7.99, intra-service time of 45 minutes, total time of 150 minutes) and noted that both services typically involve the same intra-service time and therefore should be valued similarly. The RUC concluded that CPT code 58580 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 7.21 for CPT code 58580.**

#### **Practice Expense**

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs, including the new high-cost supply item *RFA handpiece, sterile* and the *RFA dispersive electrode* as well as new equipment input, *RFA Generator System*. . The Subcommittee discussed the monitoring time in detail; converting CA023 *Monitor patient following procedure/service, no multitasking* to CA022 *Monitor patient following procedure/service, multitasking 1:4* and reducing the clinical staff time to 30 minutes to align with the standards for monitoring following procedure (standard 15 minutes of RN/LPN/MTA time per 1 hour of monitoring). The PE Subcommittee also added SA048 *pack, minimum multi-specialty visit* to the facility inputs for the bundled post-operative office visit and reduced the number of SD024 *catheter, Foley* to one. **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 58580 be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions. In September 2022, the CPT Editorial Panel replaced Category III code 0404T with the new Category I CPT code 58580 to describe transcervical radiofrequency ablation of uterine fibroid(s).

#### **Suprachoroidal Injection (Tab 10)**

**Ankoor Shah, MD (AAO), David B. Glasser, MD (AAO) and John Thompson, MD (ASRS)**

In September 2022, the CPT Editorial Panel approved the replacement of a Category III code with a Category I code to report suprachoroidal injection of a pharmaceutical agent. CPT code 67516 is a new 000-day global code that was created to describe the injection of medication into the potential space between the choroid and the sclera.

**67516 Suprachoroidal space injection of pharmacologic agent (separate procedure)**

The RUC reviewed the survey results from 106 ophthalmologists, retina specialists and uveitis specialists and determined that the survey 25<sup>th</sup> percentile work RVU of 1.53 accurately reflects the physician work necessary for this service. The RUC recommends 17 minutes pre-service evaluation time, 1 minute pre-positioning time, 5 minutes scrub/dress/wait time, 5 minutes intra-service time, 5 minutes immediate post-service time, and 33 minutes total time. The RUC discussed the short intra-service period relative to the highly intense nature of this procedure.

The physician work associated with the precise placement of the needle tip into the potential suprachoroidal space, and the location of the injection itself differs significantly from that of other intraocular and peri-ocular injections. The medication is delivered into a potential space, the suprachoroidal space, to enable depot effect and minimize certain complications. Delivery in this potential space is technically more challenging, with a different set of complications (e.g., choroidal hemorrhage) than the other injections in and around the eye. This is consistent with the need to measure the distance from the limbus and with the physician personally drawing up the medication and performing the injection. The physician typically draws up the medication personally because of the importance of maintaining sterility with an injection into the eye, the importance of getting an appropriate fill with a new device, and the high cost of the medication. The 5 minutes of intra-service time assumes success with the 900-micron needle, which must be used first. If the 1100-micron needle were used first, it would risk too deep a penetration in patients with a thin sclera. This would result in an undesirable intravitreal injection, missing the intended suprachoroidal potential space and going into the eye, which also risks serious complications, such as retinal detachment. Success is typically achieved with the smaller needle after some time is spent manipulating the angle and amount of pressure applied to both the sclera and the plunger. More than 5 minutes would be required if attempts with the 900u needle failed, necessitating a switch to the 1100u needle.

The RUC compared CPT code 67516 to the top key reference code 67028 *Intravitreal injection of a pharmacologic agent (separate procedure)* (work RVU = 1.44, 20 minutes pre-service time, 4 minutes intra-service time, and 29 minutes total time) and noted that the survey code has more intra-service and total time than the reference service and is therefore appropriately valued higher. The RUC also compared the survey code to the second key reference code 65800 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (work RVU = 1.53, 18 minutes pre-service time, 5 minutes intra-service time, and 28 minutes total time) and noted that the typical amount of physician work and intra-service time are identical. For both reference codes, a majority of survey respondents ranked the surveyed code as somewhat more or much more intense and complex on the overall intensity/complexity measure and the mental effort/judgment, technical skill/physical effort and psychological stress measures. These rankings are consistent with the requirement for placing the needle at a more precise depth of 67516 than for either of the reference service procedures. Further, the RUC acknowledged that the high intensity at the recommended work value is typical for short intraocular procedures. For additional support, the RUC referenced MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU = 1.53, 20 minutes pre-service time, 10 minutes intra-service time and 40 minutes total time) noting that the codes have identical physician work values, yet the survey code has half the intra-service and post-service time as the reference code and is therefore more intense. The RUC further referenced CPT code 27197 *Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation* (work RVU = 1.53, 12 minutes pre-service time, 5 minutes intra-service time and 27 minutes total time) to demonstrate the higher intensity of short intra-operative procedures. Both the comparator and the surveyed code have short intra-service time and similar high intensity (0.2074 and 0.195 respectively). The RUC



concluded that CPT code 67516 should be valued at the 25<sup>th</sup> percentile work RVU of 1.53 as supported by the survey. **The RUC recommends a work RVU of 1.53 for CPT code 67516.**

### **Practice Expense**

The Practice Expense Subcommittee noted that the medication, procedure-specific needles and injection kit in which these are included are reported separately with a HCPCS J-code. They also noted that extensive clinical staff time is required prior to the service as it is not typically performed in combination with an Evaluation and Management (E/M) code. Therefore, the non-facility Extensive Use of Clinical Staff time standards for a 000-day global code were approved for CA001 *Complete pre-service diagnostic & referral form*, CA002 *Coordinate pre-surgery services/review test/exam results*, and CA005 *Complete pre-procedure phone calls & prescription*. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

### **New Technology**

There is currently only one FDA-approved medication for this procedure, triamcinolone acetonide, and it is approved for only one indication: macular edema associated with uveitis. The relevant HCPCS code is J-3299. Medicare claims volume for this indication is expected to be low. However, if other drugs for more common indications obtain FDA approval, claims volume may grow substantially. Thus, **CPT code 67516 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.** The RUC recommended that if there are new drugs that have an associated J-code that these also be considered by the Relativity Assessment Workgroup as part of the New Technology screen.

### **Fraction Flow Reserve with CT (Tab 11)**

**Richard White, MD (ACC), Ed Tuohy, MD (ACC), Lauren Nicola, MD (ACR), Andy Moriarity, MD (ACR) and Kanae Mukai, MD (SCCT)**

In September 2022, the CPT Editorial Panel approved the replacement of four Category III codes with a Category I code to report non-invasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the dataset from a coronary computed tomography angiography. Specifically, non-invasive Fractional Flow Reserve with CT (FFRCT) calculates the severity of coronary artery disease in symptomatic patients and is used to enhance physician decision-making for treatment planning either medical therapy or revascularization after the initial coronary computed tomographic angiography (cCTA) is obtained.

### ***75580 Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional***

The RUC reviewed the survey results from 130 cardiologists and radiologists and determined that the survey 25<sup>th</sup> percentile somewhat overestimated the physician work typically required to perform this service. The RUC recommends a direct work RVU crosswalk to CPT code 93289 *Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements* (work RVU= 0.75, 10 minutes intra-service time and 24 minutes total time). The RUC reduced the survey pre-service evaluation time by 2 minutes to account for any pre-service physician work overlap with the original cCTA. The RUC also noted that administrative work or pre-authorization discussions are not included in pre-service time. The RUC recommends the following survey times: 5 minutes pre-service time, 11 minutes intra-service time, and 6 minutes immediate post-service time.

The RUC extensively discussed the potential overlap of physician work, as it is not necessarily the same physician who performs the initial cCTA and the interpretation. The specialty societies clarified that performing both procedures on the same day is not typical. FFRCT requires separate training and expertise such that the interpretation and report are often performed by different providers at different times. While the raw data is obtained with the cCTA, the interpretative work is performed at a subsequent date. Additionally, FFRCT is a distinctly different service than the cCTA. While the interpretation of the FFRCT includes review of the cCTA, there is no overlap or duplication of work in the two services. One cCTA is typical but must be of a high enough quality in order to perform the FFR. The interpretation is then based on the combination of the initial cCTA and the model. The specialties clarified that the report itself is a 3D interactive model with numbers that the interpreting cardiologist or radiologist can manipulate and analyze to determine the severity of coronary artery disease. The RUC discussed the new supply item, FFRCT Software Analysis, that is used to create the 3D model of the patient's coronary arteries non-invasively to provide novel assessment of coronary artery anatomy, areas of disease, and aid in reporting hemodynamic significance of any stenoses. In addition, the specialties noted and the RUC concurred that standard practice is changing for patients with active chest pain; it has shifted dramatically because the predictive accuracy of the CT angiogram and the FFRCT is far more accurate than stress-testing. In most centers, stress-testing is being replaced by FFRCT to discriminate if there is an important lesion in the coronary arteries. Finally, it was noted that the dominant specialty performing this service is cardiology. The RUC concurred that applying CPT code 93289 as a direct crosswalk to CPT code 75580 is appropriate.

To justify the crosswalk, the RUC compared the surveyed code to the top key reference code 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.62, 20 minutes intra-service time and 40 minutes total time) which is a clinically similar code also used to evaluate cardiac function. The reference code has greater overall times, which is required because it includes evaluation of a greater number of structures and variables compared to the surveyed code and is therefore appropriately valued higher.

The RUC also compared the surveyed code to the second highest key reference code 93308 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study* (work RVU = 0.53, 10 minutes intra-service time and 20 minutes total time), noting that it is a good clinical comparator. The surveyed code has one minute more intra-service time and is more intense as it involves consideration of a larger amount of diagnostic data in formulating the interpretation and recommendations compared to the key reference code, justifying the higher work value for 75580.

For additional support, the RUC referenced 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) and noted that the ultrasound code typically requires the same intra-service time as the survey code but is a more intense service to perform and is therefore appropriately valued higher. The RUC concluded that CPT code 75580 should be valued based on a direct work RVU crosswalk to CPT code 93289 and agreed the crosswalk value slightly below the survey 25<sup>th</sup> percentile was appropriate. **The RUC recommends a work RVU of 0.75 for CPT code 75580.**

***75574 Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)***

The specialty societies developed recommendations to value newly created CPT code 75580 but did not survey or develop new work or practice expense recommendations for existing CPT code 75574. The specialty societies submitted a letter to explain why they believe that code 75574 is not part of the family and that performance of 75574 with 75580 is not typical. The specialties indicated that the 2020 Medicare claims data which shows deleted FFRCT category III code 0504T reported with cCTA CPT code 75574 67% of the time is not accurate or reflective of the way the services are typically provided to patients in 2023. While the raw data is obtained on any given day, the specialties noted that the interpretative work is typically performed on a subsequent date. The RUC concluded that, although most of the time the FFR is performed with a recently completed cCTA, the converse is not true as the volume of 75574 was more than 20 times higher than 0504T. Therefore, the RUC does not believe that the cCTA code must be surveyed and believes that any overlap has been eliminated. The RUC also noted that CPT code 75574 was reviewed by the Relativity Assessment Workgroup in 2021 and the RUC determined the growth was appropriate with no further action based on the High-Volume Growth screen. **The RUC accepts the specialty societies' request not to survey CPT code 75574 and will not offer a recommendation.**

**Practice Expense**

The Practice Expense Subcommittee discussed the new supply input *FFRCT Software Analysis* and confirmed that the \$1,100 is a per patient cost and that the software is not owned by the physician's practice, thus is not reusable. The Subcommittee emphasized the benefit of creating HCPCS codes for this type of high-cost supply item as the cost of the supply will be added to each study. The Subcommittee also noted that imaging and diagnostic services are comprised of two components: a professional component (PC) and a technical component (TC). For CPT code 75580, the PC and TC may be furnished independently or by different physicians or facilities, or they may be furnished together as a global service. **The RUC recommends the direct practice expense inputs as submitted by the specialty society. In addition, the RUC recommends that a PC/TC split be applied for CPT code 75580.**

**New Technology**

CPT code 75580 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Percutaneous Coronary Interventions (Tab 12)**

**Richard Wright, MD (ACC), Ed Tuohy, MD (ACC), Mark Hoyer, MD (SCAI) and Afnan Tariq, MD, JD (SCAI)**

**Referral to the CPT Editorial Panel**

In October 2010, CPT code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* was identified by the Relativity Assessment Workgroup (RAW) via the MPC List screen. The RAW requested that the specialty societies survey this code for RUC review. Subsequently, the specialty society referred the code to the CPT Editorial Panel to revise the family of procedures to more accurately describe the current physician work involved in PCI. At the October 2011 CPT meeting, the Panel approved 13 new codes to describe PCI services. The societies surveyed the family and the RUC submitted recommendations to the Centers for Medicare & Medicaid Services (CMS) in January 2012. Instead of accepting the RUC recommendations, CMS opted to assign bundled status to all the add-on codes for the additional branches off the major coronary arteries (codes 92921, 92929, 92934, 92938,

92944). In addition, CMS increased values and intra-times of all the base codes using a mathematical formula to include a fraction of the time and value of the add-on codes, based on the billed together data available at the time. For example, using 2011 Medicare claims data, CMS anticipated that the service described by add-on code 92921 would be performed with the procedure described by base code 92920 27.4% of the time. To bundle the work value of the add-on code into base code 92920, CMS multiplied the RUC recommendation for the add-on code of 4.00 by 27.4% (or 1.10) and added that fractional value to the RUC recommendation for the base code (9.00+1.10=10.10). The value of moderate sedation, which was bundled into the base codes, was systematically removed when separate moderate sedation CPT codes were created for CPT 2017.

In September 2022, the CPT Editorial Panel created one new Category I CPT code for percutaneous coronary lithotripsy. Sixteen other percutaneous coronary intervention (PCI) codes were considered part of the code family.

For the January 2023 RUC meeting, the specialty societies opted to survey nine of the sixteen codes. The specialty societies opted to not survey the add-on codes in the family that describe intervention in additional branches off major coronary arteries. CMS and payers have never recognized these add-on codes as separately payable services, therefore they have no Medicare utilization. The specialty societies noted they did not want to confuse respondents by asking them to survey codes with which they are not familiar or to lengthen the survey for services that are not separately reportable. As part of the societies' plans for future updates to this family of codes, the societies noted their intention is to delete add-on codes for PCI in additional branches.

After reviewing the survey results in preparation for the January 2023 RUC meeting, the surveying specialty societies requested, and the RUC agreed, to submit a recommendation only for the new add-on code 92972 for CPT 2024 and referred the entire percutaneous coronary intervention code family to the CPT Editorial Panel for restructuring for the CPT 2025 cycle.

The specialty societies noted that their intent is to update the CPT code structure for PCI services to incorporate the bundling of the branch services and to account for modern technology and changes in the techniques used to provide these services.

The specialties also explained that PCI is now typically performed through the radial artery, reflecting best practice recommendations from the field. Research has shown the radial approach to be safer for patients despite being technically more challenging for the operator. The main advantage is a significant reduction in the risk of patient bleeding. At the time of the prior survey, PCI was typically performed via the femoral artery, with a very small minority of cases performed through the radial artery; PCI via the radial artery was just emerging in this country.

**The RUC recommends that existing CPT codes 92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944, 92973, 92975, 92977 and new add-on code 92972 be referred to the CPT Editorial Panel for revision in the 2025 CPT cycle.** It is the expectation of the RUC that the specialties will submit their code change application for the September 2023 CPT meeting and survey new and/or revised codes within the 2025 CPT cycle.

***92972 Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 139 interventional cardiologists and noted that the survey respondents overestimated the typical physician work required to perform this add-on code. Therefore, the RUC recommended a direct work RVU crosswalk to CPT Code 37249 *Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and*

*radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure) (work RVU= 2.97, intra-service and total time of 30 minutes) and noted that both services typically involve the same amount of intra-service and total time and similar physician work intensity.*

Code 92972 is a new Category I code to report intravascular lithotripsy (IVL) as an add-on to other PCI services. IVL is a new revascularization treatment option, in which pulsating sonic pressure waves pass through soft tissue and selectively interact strongly with high-density calcium, producing significant shear stresses that have the ability to fracture the calcium. Arterial calcification is associated with increased cardiovascular risks. Intimal arterial calcification (IAC), considered a representation of underlying atherosclerotic plaque burden, has long been held responsible for this association, whereas increasing interest is directed towards medial arterial calcification (MAC). IVL is designed to modify both intimal and medial calcium across a wide range of vascular applications to increase vessel compliance, restore vessel mobility and provide new versatile treatment options for patients. Coronary IVL received pre-market approval on February 12, 2021, from the FDA for lithotripsy-enabled, low-pressure balloon dilatation of severely calcified, stenotic de novo coronary arteries prior to stenting.

The RUC compared the surveyed code to reference CPT code 67335 *Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)* (work RVU= 3.23, intra-service and total time of 30 minutes) and CPT code 32668 *Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)* (work RVU= 3.00, intra-service and total time of 30 minutes) and noted that all three services typically involve an identical amount of time and similar physician work intensities to perform. The RUC concluded that CPT code 92972 should be valued based on a direct work RVU crosswalk to CPT code 37249 and agreed the crosswalk value below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 2.97 for CPT code 92972.**

### **Practice Expense**

No direct practice expense inputs are recommended for CPT code 92972 as it is a facility-based add-on service.

### **Pelvic Exam (PE Only) (Tab 13)**

**Megan Adamson, MD (AAFP), Jon Hathaway, MD (ACOG), Mitch Schuster, MD (ACOG), Eileen Attwood, MD (ACOG), Korinne Van Keuren, DNP, APRN (ANA), Thomas Turk, MD (AUA), Jonathan Kiechle, MD (AUA), Jyoti Chouhan, MD (AUA) and Drew Peterson, MD (AUA)**

In response to the January 2022 Relativity Assessment Workgroup (RAW) discussion on gender equity payment, a RUC member commented that the preventive medicine services codes 99381-99397 could be reviewed by the RAW for potential 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 concluded to refer this item to the RAW for further review of gender-based differences in preventive medicine services. In April 2022, presenters from the American College of Obstetricians and Gynecologists (ACOG) indicated, and the RAW agreed, that there may be additional resources associated when a pelvic examination is performed. The RAW agreed that this

issue should be referred to the CPT Editorial Panel to consider the specialty's request for additional code(s) to describe pelvic examinations.

In September 2022, the CPT Editorial Panel created a new CPT code for reporting a pelvic exam. During creation of the code, the specialty societies noted that, "the additional physician or qualified healthcare professional (QHP) work included in performing the pelvic exam at the same time the physician or QHP is performing a problem-oriented E/M service would be captured in the E/M code (99202-99205, 99212-99215 and 99242-99245) selection. For example, if the physician or QHP is using time as the E/M code selection criteria, the time to perform the pelvic exam would count toward the time used to select the appropriate level of E/M service. The same would be true if the physician or QHP was using medical decision making as their E/M code selection criteria." The CPT Editorial Panel agreed, thus the new code is a practice expense only code that captures the direct practice expenses associated with performing a pelvic exam in the non-facility setting. The Practice Expense (PE) Subcommittee reviewed the practice expense inputs at the January 2023 RUC meeting.

**99459 Pelvic exam (List separately in addition to code for primary procedure) (Use 99459 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397)**

The PE Subcommittee discussed the direct practice expense inputs and made no modifications to the specialty societies' submission. The PE Subcommittee noted that the 4 minutes of clinical staff time for 99459 were appropriate as CA018 *Assist physician or other qualified healthcare professional--- directly related to physician work time (100% of physician intra-service time)* captures the time associated with chaperoning a pelvic exam. The specialty societies' supporting evidence identifies the best clinical practices for a chaperone to be present for all breast, genital, and rectal examinations regardless of the sex or gender of the person performing the examination. There are no additional clinical activities recommended as the physician work of performing the pelvic exam is included in the primary code. There is one standard supply pack, SA051 *pack, pelvic exam*, which was deemed appropriate for performing a pelvic exam. Additionally, there are only two equipment items, EQ168 *light, exam*, and EF023 *table, exam*, deemed appropriate as they are standard inputs for use in the physician office setting and the light is necessary for the pelvic exam. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

#### **Venography Services (Tab 14)**

**Richard Wright, MD (ACC), Ed Tuohy, MD (ACC), Mark Hoyer, MD (SCAI) and Afnan Tariq, MD, JD (SCAI)**

In May 2020, the CPT Editorial Panel replaced a family of four cardiac catheterization codes with five new codes to describe cardiac catheterization for congenital cardiac defect(s). In addition, the Panel replaced two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects. In October 2020, the RUC reviewed and valued these six new 000-day global codes (93593-93598), which CMS implemented in the Medicare Physician Payment Schedule (MFS) effective January 1, 2022.

In February 2022, the CPT Editorial Panel approved the creation of six new add-on codes (93584-93588) for venography services. The services described by 93584 and 9X001 were previously reported using more general CPT codes 75827 *Venography, caval, superior, with serialography, radiological supervision and interpretation* and 75825 *Venography, caval, inferior, with serialography, radiological supervision and interpretation*, respectively; these previous codes were not solely for patients with congenital defects. The services described by codes 93586-93588 were

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previously reported with an unlisted code for cardiovascular services or procedures. These newly created codes represent add-on services that are performed during cardiac catheterization for congenital heart defects in the superior vena cava (SVC), the inferior vena cava (IVC), and in other congenital veins. The intention of the new codes was that they be reported with the corresponding 000 global cardiac catheterization codes.

At the April 2022 RUC meeting, the RUC recommended that existing CPT codes 93593-93598 and new add-on codes 93584-93588 be referred to the CPT Editorial Panel for further clarification within the CPT 2024 cycle. The distinctions between current coding and the newly created services were unclear and required revision by CPT to accurately explain whether the catheter placement performed for venography is part of a congenital cardiac catheterization. In September 2022, the CPT Editorial Panel approved the revision of the five new add-on codes (93584, 93586-93588) and rescinded 9X001 *Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; inferior vena cava (List separately in addition to code for primary procedure)*. The codes were revised at the September 2022 CPT Editorial Panel meeting and surveyed for the January 2023 RUC Meeting.

### **Intensity**

Selective catheter placement in anomalous congenital venous structures is not included in the base congenital cardiac catheterization codes. Therefore, add-on codes in the venography services family include selective catheter placement in the specific venous structure(s) being imaged as well as venography and radiologic supervision and interpretation. The RUC noted that there is a dearth of ZZZ comparator codes with similar time and intensity as CPT codes 93584 and 93586 – 93588. Recognizing that intensity is especially sensitive to time for ZZZ services, which generally have shorter procedure times and only include intra-service time (no pre/post-service time or visits), the RUC acknowledged that the recommended values would be the highest for ZZZ codes with commensurate intra-service time. However, the RUC concurs that the values are justified given the intensity of the physician work for these procedures, which involve the use of different catheters and wire combinations to navigate to the target location in surgically altered or congenital-altered anatomy. These codes are for all patient ages, recognizing that the physician work becomes especially intense and complex when the patients are infants.

Moreover, the add-on services for the venography services family comprise more complex, detailed physician work than the underlying cardiac congenital catheterization codes and have appropriately higher intensity than these base codes. While the RUC notes that it is uncommon for an add-on code to be more intense than the underlying service, it does occur. A relevant example is trans-septal puncture CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) that may be performed with SVT ablation CPT code 93654 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed* (work RVU = 18.10, 200 minutes intra-service and 291 minutes total time). The puncture procedure is more intense than the ablation. Similarly, for example, the base code 93593 *Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections* (work RVU = 3.99, 45 minutes intra-service and 148 minutes total time) is less intense than the additional code

93584 where, if present, a second superior vena cava that requires incorporation into a surgical cavopulmonary anastomosis is entered.

**93584 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 42 congenital interventional cardiologists and determined that the survey 25<sup>th</sup> percentile work RVU of 1.20 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 10 minutes intra-service and total time as supported by the survey. The work of 93584 is considerably complex, requiring extensive catheter manipulation in the second superior vena cava. Moreover, the less intense work of the base code has already been completed. As such, 93584 is highly intense from the first minute.

It was noted that CPT code 75827 *Venography, caval, superior, with serialography, radiological supervision and interpretation* (work RVU= 1.14), which is a CMS/Other valued code, is to be reported when a normal SVC is performed. For coding purposes, the term “anomalous/persistent left or right SVC” refers to a second SVC on the opposite side of the chest from the first SVC. For example, in typical cardiac anatomy, the SVC is on the right side and a persistent left SVC would be on the left side. In situs inversus, the SVC would typically be located on the left side of the chest, and a persistent right SVC would be on the right side. In heterotaxy, bilateral SVCs are common. In these scenarios, venography of the first SVC would be reported with 75827, and catheter placement and venography of the persistent/anomalous SVC would be reported with 93584. Formerly, the additional work of performing the persistent/anomalous SVC was reported using unlisted code 93799. The RUC concurred with the specialties that performing catheter placement and venography of the persistent/anomalous SVC on a pediatric patient with this congenital defect is more intense/complex than performing venography of the SVC in typical cardiac anatomy of an adult patient.

It was also noted that catheter placement in a normal SVC is considered part of the base congenital cardiac catheterization codes. Whereas selective catheter placement in anomalous congenital venous structures is not included in the base congenital cardiac catheterization service and is separately included in the new add-on congenital venography CPT codes.

The RUC compared the surveyed code to the top key reference service and MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the surveyed code requires less time and intensity than the reference code and is therefore appropriately valued lower. The RUC also compared the surveyed code to the second highest key reference service code 75774 *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 1.01, 30 minutes intra-service and total time) and noted that the surveyed code requires much less time and much greater intensity than the reference code and is therefore appropriately valued higher. A key difference between these two key reference services is the first includes catheter placement and the latter does not, thus the significant variability in their values.

For additional support, the RUC referenced MPC code 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service and 21 minutes total time)



and noted that the intra-service time is higher and the intensity is lower than the surveyed code. The RUC concluded that CPT code 93584 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.20 for CPT code 93584.**

***93586 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemi-azygos venous system (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 42 congenital interventional cardiologists and determined that the survey 25<sup>th</sup> percentile work RVU of 1.13 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 10 minutes intra-service and total time as supported by the survey. The work of 93586 is considerably complex as it requires significant and extensive catheter manipulation. It was noted that, if catheter entry is superior to the heart, it is more complicated than inferior access.

The RUC compared the surveyed code to the top key reference service code 75774 *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 1.01 and 30 minutes intra-service time) and noted that the surveyed code requires much less time and much greater intensity than the reference code and is therefore appropriately valued higher. The RUC also compared the surveyed code to the second highest key reference service MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 15 minutes intra-service time) and noted that the surveyed code requires less time and intensity than the reference code and is therefore appropriately valued lower. The RUC concluded that CPT code 93586 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.13 for CPT code 93586.**

***93586 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 42 congenital interventional cardiologists and determined that the survey 25<sup>th</sup> percentile work RVU of 1.43 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 12 minutes intra-service and total time as supported by the survey. The work of 93586 is considerably complex as it requires significant and extensive catheter manipulation. Within the code family, the coronary sinus is typically normal, without congenital defects, however, the drainage patterns, size, and stenosis can vary which can increase the complexity of the venography.

The RUC compared the surveyed code to the top key reference service MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the surveyed code requires less time and intensity than the reference code and is therefore appropriately valued lower. The RUC also compared the surveyed code to the second highest key reference service code 75774 *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 1.01, 30 minutes intra-service and total time) and noted that the surveyed code requires much less time and much greater intensity than the reference code and is therefore appropriately valued higher.

For additional support, the RUC referenced MPC code 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service and 21 minutes total time) and noted the close comparison in the amount of physician work involved in the procedures. The RUC concluded that CPT code 93586 should be valued at the 25<sup>th</sup> percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.43 for CPT code 93586.**

**93587 *Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (eg, from innominate vein) (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 42 congenital interventional cardiologists and determined that the survey median work RVU of 2.11 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 16 minutes intra-service time as supported by the survey. The work of 93587 is more complex as it requires significantly different and more extensive catheter manipulation and injecting various venovenous (VV) collaterals. These VV collaterals are not present at birth, instead, they develop as complications of chronically high systemic venous pressures. The physician work for this procedure is typically performed on two vessels that are difficult to reach. Moreover, there is no pre-procedure imaging to determine the vessels so the physician must search for them, adding to the complexity.

The RUC compared the surveyed code to the top key reference service MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the surveyed code has similar time and intensity as the reference code and should therefore be valued similarly. The RUC also compared the surveyed code to the second highest key reference service code 75774 *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 1.01, 30 minutes intra-service and total time) and noted that the surveyed code has much less time but much greater intensity than the reference code and is therefore appropriately valued higher.

For additional support, the RUC referenced CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and 20 minutes intra-service time) and noted the greater amount of time and physician work involved with the comparison procedure. The RUC concluded that CPT code 93587 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 2.11 for CPT code 93587.**

**93588 *Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating below the heart (eg, from the inferior vena cava) (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 42 congenital interventional cardiologists and determined that the survey median work RVU of 2.13 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 17 minutes intra-service and total time as supported by the survey. The work of 93588 is significantly more complex as it requires significantly different and more extensive catheter manipulation as the congenital anomaly can be in a different place in every patient. The existence of anomalous systemic venous return often requires an additional venous cannula during cardiopulmonary bypass, heightening the importance of identification for pre-

operative planning. Systemic venous anomalies may create an increase in technical and procedural complexity by making it more challenging to obtain essential information during cardiac catheterization or by necessitating alternative vascular access sites to perform catheterization procedures. The venovenous (VV) collaterals are not present at birth, instead, they develop as complications of chronically high systemic venous pressures. The physician work for this procedure is typically performed on two vessels that are difficult to reach. Moreover, there is no pre-procedure imaging to determine the vessels so the physician must search for them, adding to the complexity.

The RUC compared the surveyed code to the top key reference service MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the surveyed code has similar time and intensity as the reference code and should therefore be valued similarly. The RUC also compared the surveyed code to the second highest key reference service code 75774 *Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 1.01, 30 minutes intra-service and total time) and noted that the surveyed code has much less time but much greater intensity than the reference code and is therefore appropriately valued higher.

For additional support, the RUC referenced CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50, 20 minutes intra-service and total time) and noted that the surveyed code has less time and similar intensity. The RUC concluded that CPT code 93588 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 2.13 for CPT code 93588.**

#### **Affirmations**

**The RUC affirms the October 2020 RUC recommendations for CPT codes 93593-93598 and notes that CMS reduced the value of codes 93595-93598. Thus, the RUC continues to recommend the following work RVUs: 3.99 for CPT code 93593, 6.10 for CPT code 93594, 6.00 for CPT code 93595, 7.91 for CPT code 93596, 9.99 for CPT code 93597 and 1.75 for CPT code 93598.**

#### **Practice Expense**

No direct practice expense inputs are recommended for CPT codes 93584 and 93586 – 93588 as they are facility-based add-on services.

#### **New Technology**

CPT codes 93584 and 93586 – 93588 will be placed on the New Technology list and will be re-reviewed on the same timeline as the family of codes 93593-93598 from October 2020 to ensure correct valuation and utilization assumptions.

#### **Hyperthermic Intraperitoneal Chemotherapy (Tab 15)**

**Jon Hathaway, MD, PhD (ACOG) and David Holtz, MD (ACOG), Charles Mabry, MD (ACS) and Don Selzer, MD (ACS)**

In September 2022, the CPT Editorial Panel created two time-based add-on Category I codes 96547 *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for*

*primary procedure*) and 96548 *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)*. HIPEC was previously reported with code 96549 *Unlisted chemotherapy procedure*, however, the unlisted code is not specific and does not account for the variable time required for this intraoperative add-on procedure. The CPT Editorial Panel also made editorial revisions to code 96446 to indicate chemotherapy administration via an implanted port or catheter and added a parenthetical related to the two new codes.

CPT codes 96547 and 96548 were surveyed for the January 2023 RUC meeting. In preparation for the survey, the specialty societies noted that the work involved with these add-on codes includes not just the chemotherapy dwell time, but also work that is exclusive to the primary service, such as additional equipment setup, incisions and closures, plus dwell time/solution manipulation. Given this information, the specialty societies requested, and the Research Subcommittee agreed, to customize the ZZZ survey template to add additional instructions that defined each service period and added fields to collect pre- and post-time. The survey template revisions were created in tandem with the specialty societies to ensure that the survey times and work of the new add-on codes were accurate and did not overlap with any potential work of the primary procedure.

The survey was sent to a random sample of surgical oncologists from two specialty societies collecting a total of 36 responses. While reviewing the survey data, it was clear to the specialty societies that the instructions were not sufficient as the survey data reflected time estimates that far exceed the time specified in these new time-based code descriptors. The RUC agreed that the survey respondents may not have fully understood the survey instructions as the data demonstrates a bi-modal distribution with half of the respondents indicating that the survey time was more than the descriptor time (ie, 60 minutes) and the other half indicated a time within the stated descriptor time. The RUC also indicated that the CPT descriptor did not clearly define the work included in the stated time and noted the descriptor should be clarified via the CPT process. After thorough review, the specialty societies indicated, and the RUC agreed, that the survey results for both CPT codes 96547 and 96548 were inaccurate and that the codes should be resurveyed within the 2025 CPT cycle with a targeted survey tool that has been reviewed and approved by the Research Subcommittee. **Therefore, the RUC recommends contractor pricing for CPT codes 96547 and 96548. The RUC also recommends that CPT codes 96547 and 96548 be referred to the CPT editorial Panel for revision in the 2025 CPT cycle. The specialty societies will resurvey within the 2025 CPT cycle and work with the Research Subcommittee to draft a targeted survey.**

#### **Referral to CPT**

During the discussions, the RUC determined that the CPT descriptor did not clearly define the work included in the stated descriptor time (ie, 60 minutes) and recommended that the two new codes be referred to the CPT Editorial Panel for further clarification. The RUC noted that new codes related to tumor resection prior to HIPEC were being brought to the Panel by the specialty societies within the 2025 CPT cycle and those new base codes would further clarify the two new time-based add-on codes in the re-survey during the 2025 cycle.

#### **Practice Expense**

The RUC recommends no direct practice expense inputs for CPT codes 96547 and 96548 as they are facility-only services.

## X. CMS Request/Relativity Assessment Identified Codes

### **Hyperbaric Oxygen Under Pressure (Tab 16)**

**Megan Adamson, MD (AAFP), Brad Fox, MD (AAFP), Helen Gelly, MD (UHMS) Kaye Moseley, RRT (UHMS) and Mike White, MD (UHMS)**

Code G0277 *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval* was identified via the high volume growth screen for codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2022. At the September 2022 Relativity Assessment Workgroup meeting, the specialty societies proposed to review the direct practice expense inputs for the January 2023 RUC meeting.

In January 2023, the Practice Expense Subcommittee reviewed G0277 and had no modifications to the direct practice expense inputs submitted by the specialty societies. The PE Subcommittee accepted compelling evidence there has been a change in the dominant specialty providing this service and a change in clinical staff type. Previously this service was primarily performed by general surgery, internal medicine, and undersea and hyperbaric medicine, whereas now family medicine is the top specialty. It is now typical for a single staff person (L047C *RN/respiratory therapist*) to perform all tasks rather than divide activities among two staff (an RN/LPN/MA and an RN/respiratory therapist). Additionally, as of 2016, the National Board of Diving and Hyperbaric Medical Technology no longer allows certified nursing assistants and certified medical assistants to be eligible to take the certified hyperbaric technologist examination, and as such, there has been a change in the clinical staff type. The PE Subcommittee agreed with the specialty societies to update the clinical staff type to reflect solely L047C *RN/Respiratory Therapist*.

The PE Subcommittee reviewed how hyperbaric oxygen therapy is administered. Typically, there is one patient in one hyperbaric chamber for two hours. There are no patients who utilize the chamber for only 30 minutes; two hours is typical, and it is relatively uncommon to use it for longer. Therefore, the direct practice expense inputs reflect that typical service. All the inputs submitted are prorated for four units typically being performed (30 minutes each, totaling 2 hours). For example, the supplies have all been divided into quarters such as SM025 *specula tips, otoscope*, which is listed as 0.50 and equates to two specula tips that are used before and after treatment. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

### **RUC Referral to CPT**

The RUC noted that CMS created G0277 in 2015 to describe the direct practice expense inputs associated with CPT code 99183 *Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session*. In the Final Rule for 2015, CMS commented that CPT code 99183 is used for both professional attendance and supervision and the actual treatment delivery. Stakeholders pointed out that although CMS included the PE inputs for treatment delivery in CPT code 99183, the descriptor describes only attendance and supervision. CMS noted that under the Outpatient Prospective Payment System (OPPS), the treatment is reported using separate treatment code C1300 *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval*. Therefore, CMS created code G0277 to report the treatment delivery and to maintain consistency with the OPPS coding. CMS used a timed 30-minute code, which can be used across settings. To value G0277, CMS used the RUC recommended direct PE inputs for 99183 and adjusted them to align with the 30-minute treatment interval.

**The RUC recommends that CPT code 99183 be referred to CPT by the June 2023 deadline for the September 2023 CPT meeting, for revision to be time-based as well as modified to appropriately describe the treatment delivery, attendance and supervision. Then, subsequently, allow for the deletion of G0277.**

**Telehealth Consultation – ED or Initial Inpatient (Tab 17)**

**No Specialty Interest**

In September 2022, the Relativity Assessment Workgroup identified G0425 *Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth* as a CMS/Other source code with Medicare utilization over 20,000. The RUC recommended G0425 be surveyed for January 2023. At the October 3, 2022, Research Subcommittee meeting, there was a discussion regarding which vignettes were being developed for these services and about adding the associated subsequent visit codes (G0406, G0407 and G0408) as part of the family. Subsequently, the specialty societies submitted a change in level of interest from level 1 (survey) to level 2 (comment only). Therefore, no specialty surveyed these services. The specialty societies noted concerns in surveying these services, such as difficulty defining the typical patient, discrepancy of time in the G-code descriptors with the new E/M definitions, and a lack of involvement from the dominant specialties after the addition of subsequent codes G0406-G0408. **The RUC will not offer a recommendation on codes G0425, G0426 or G0427 as no specialty society expressed an interest in surveying and/or developing a recommendation to the RUC.**

**Flag for Relativity Assessment Workgroup**

The RUC agreed that the CPT/RUC Telemedicine Office Visits Workgroup is working on addressing services performed via audio-visual and audio only. **The RUC determined that CMS should replace these G codes once the CPT 2025 telemedicine codes are available. The RUC recommends that the Relativity Assessment Workgroup review G0425-G0427 in April 2029 after three years of data are available. If there is no action on these services for CPT 2025, the RAW should review them in two years (April 2025).**

**Ocular Surface Amniotic Membrane Placement/Reconstruction (Tab 18)**

**Brad Fouraker, MD (AAO), Ankoor Shah, MD (AAO), David Glasser, MD (AAO) and Charles Fitzpatrick, OD (AOA)**

CPT code 65778 *Placement of amniotic membrane on the ocular surface; without sutures* was identified by the Relativity Assessment Workgroup (RAW) via the high-volume growth screen for codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2015 through 2022. At the September 2022 RAW meeting, the specialty societies indicated their plan to survey CPT codes 65778, 65779 and 65780 for the January 2023 RUC meeting.

***65778 Placement of amniotic membrane on the ocular surface; without sutures***

The RUC reviewed the survey results from 66 ophthalmologists and optometrists and determined that the survey 25<sup>th</sup> percentile work RVU of 0.84 appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes pre-service evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 5 minutes intra-service time and 5 minutes post-time. The specialty societies reduced the survey respondents positioning time from 4 minutes to 1 minute to match the pre-time package.

CPT code 65778 describes placement of a self-retaining amniotic membrane graft on the cornea and conjunctiva. It is used to reduce inflammation and promote epithelial healing typically in patients with persistent corneal epithelial defects that are unresponsive to conservative therapy. Essentially it

is a large, uncomfortable, thick, device somewhat like a hard contact lens, with a membrane that is placed on the eye and remains on the eye for an extended period.

This service is typically not performed on the same day as an office visit Evaluation and Management (E/M) service (16%) or an eye E/M visit (28%). The reasons that this service is typically not performed on the same day are because amniotic membrane devices are expensive and have a relatively short shelf life. Many practices order them on a case-by-case basis for rapidly progressive diseases, and patients are asked to schedule a return visit for placement and re-evaluation. At that time, aggressive conservative therapy is typically initiated. When the patient returns, a re-evaluation is performed. If conservative therapy is working, the physician does not place the membrane and it is returned to the supplier. In that case the physician reports an office E/M or an eye visit E/M service.

The RUC agreed with the specialty societies that this service has not changed since it was last valued in 2015. However, the previous valuation was based on a crosswalk and marked not to use to validate physician work for other services in the RUC database. Therefore, the RUC determined that the current survey 25<sup>th</sup> percentile work RVU of 0.84 based on a valid survey, is most appropriate to value this service. The RUC compared the surveyed code to the top key reference code 65222 *Removal of foreign body, external eye; corneal, with slit lamp* (work RVU = 0.84, 7 minutes intra-service time and 15 minutes total time) and determined the amount of physician work is the same although the surveyed code requires more than twice the amount of physician time. The RUC reviewed the second top key reference service 65800 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (work RVU = 1.53, 5 minutes intra-service time and 28 minutes total time) and agreed that while the surveyed code has identical intra-service time to 65800, this reference code is a more intense procedure and is accurately valued higher.

For additional support, the RUC referenced CPT code 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU = 1.00, 5 minutes intra-service time and 18 minutes total time), which has identical intra-service time, analogous total time, and provides appropriate relativity to the surveyed code. Additionally, code 36005 *Injection procedure for extremity venography (including introduction of needle or intracatheter)* (work RVU = 0.95, 5 minutes intra-service time and 25 minute total time) and code 51720 *Bladder instillation of anticarcinogenic agent (including retention time)* (work RVU = 0.87, 5 minutes intra-service time and 19 minutes total time) have identical intra-service time, similar total time, and require slightly more work than CPT code 65778. **The RUC recommends a work RVU of 0.84 for CPT code 65778.**

#### **65779 Placement of amniotic membrane on the ocular surface; single layer, sutured**

The RUC reviewed the survey results from 34 ophthalmologists and determined that the survey 25<sup>th</sup> percentile work RVU of 1.75 appropriately accounts for the work required to perform this service. The RUC recommends 13 minutes pre-service evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time and 7 minutes post-time. The specialty societies reduced the survey respondent's evaluation time from 27 to 13 minutes and positioning time from 5 minutes to 1 minute to match the pre-time package.

CPT code 65779 is a 000-day global code that describes preparation of the ocular surface and suturing amniotic membrane graft in place to control inflammation and promote corneal healing. This service is typically performed in the facility setting and is not typically reported with an E/M or eye E/M. The specialty society noted that although the procedure and instrumentation have not changed since the last valuation in 2015, the reduction in intra-service time is related to gradual familiarization with the process of suturing the delicate amniotic membrane in place. The RUC notes that the decrease in physician time is aligned with the recommended decrease in work RVU.

The RUC compared the surveyed code to the top key reference code 12016 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm* (work RVU = 2.68, 30 minutes intra-service time and 47 minutes total time) and determined that although the surveyed code requires only one minute less total time, it requires one-third less intra-service time and requires less intensity, complexity and physician work. The RUC reviewed the second top key reference service 12015 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm* (work RVU = 1.98, 25 minutes intra-service time and 37 minutes total time) and determined that the surveyed code requires more pre-service time but less intra-service time and is overall less intense and complex. The specialty societies indicated, and the RUC agreed that the only change since the last valuation has been the speed with which the physicians can suture the delicate amniotic membrane without damaging it. Therefore, there was no compelling evidence to increase above the survey 25<sup>th</sup> percentile. **The RUC recommends a work RVU of 1.75 for CPT code 65779.**

**65780 Ocular surface reconstruction; amniotic membrane transplantation, multiple layers**

The RUC reviewed the survey results from 47 ophthalmologists and determined that a work RVU of 7.03, a direct crosswalk from CPT code 29822 *Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])* (work RVU = 7.03, 30 minutes intra-service time and 191 minutes total time) appropriately accounts for the physician work required to perform this service. The RUC recommends 13 minutes pre-service evaluation time, 1 minute positioning time, 6 minutes scrub/dress/wait time, 35 minutes intra-service time, 10 minutes immediate post-time, a half 99238 discharge day management, 1-99212 and 4-99213 post-operative office visits. The specialty societies reduced the survey respondents' evaluation time from 19 to 13 minutes and reduced the positioning time from 5 minutes to 1 minute to match the pre-time package.

CPT code 65780 is a 090-day global period service that is typically performed in the facility setting describing a debridement of severely compromised ocular surface and thinned cornea with multiple layers of amniotic membrane transplantation to reinforce the cornea and promote epithelial healing. This service is not typically reported with an office E/M or eye visit E/M and has not changed since it was last valued in 2015. The specialty societies attribute the reduction in intra-service time to improved instrumentation and packaging and increased experience with handling the fragile membrane without damaging it.

The first post-operative 99212 visit is typically performed the day after surgery to check vision, pressure, incision and graft integrity, and pain. At every subsequent 99213 post-operative visit, in addition to vision and pressure measurements and an interval history, a careful slit lamp examination through the amniotic membrane graft is required to assess the degree of surface inflammation, suture integrity and exposure, corneal thickness, evidence of progressive corneal melting or infiltration, and epithelial healing. Each of these findings is used to assess the appropriate topical medication regimen until the next visit. This typically consists of a combination of topical corticosteroids, antibiotics, NSAIDs, and lubricants, all of which require dosing adjustments until the next visit. In addition, the sutures begin loosening within a week after surgery, contributing to patient discomfort and increasing the risk of infection. Non-absorbable nylon is typically used as it produces less inflammation than absorbable materials. These sutures need to be removed as they loosen, typically 2 or 3 of the more superficial sutures at each of the early post-operative visits, and then more of the deeper sutures as they loosen and migrate to the surface. The time required for the examination, the level of medical decision



making associated with medication adjustments, and the need to remove sutures, warrant a level 3 visit at each of the four post-operative visits after the one post-operative 99212 visit.

The RUC compared the surveyed code to the top key reference service 66185 *Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft* (work RVU = 10.58, 65 minutes intra-service time, 4-99213 and 3-99212 post-operative visits) and the second top key reference service 66184 *Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft* (work RVU = 9.58, 60 minutes intra-service time, 4-99213 and 3-99212 post-operative visits). Both key reference services require substantially longer intra-service time than the surveyed code and more post-operative visits to manage a filtering bleb. The RUC determined since the surveyed service requires less physician work, less time and fewer post-operative visits, it should be valued lower. Thus, the RUC recommend CPT code 65780 be crosswalked to 29822, which requires the same physician work and almost identical total time of 192 and 191 minutes. The reduction in work value is consistent with the decrease in intra-service time and the change in post-operative visits that have occurred over time while maintaining the intensity and complexity of this service.

For additional support, the RUC referenced CPT code 29881 *Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU = 7.03, 40 minutes intra-service time and 194 minutes total time) and noted that 29881 requires the same physician work and similar total time as the surveyed code. The RUC concluded that CPT code 65780 should be valued based on a direct work RVU crosswalk to CPT code 29822 and agreed the crosswalk value below the survey 25<sup>th</sup> percentile was appropriate. **The RUC recommends a work RVU of 7.03 for CPT code 65780.**

#### **Practice Expense**

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. The specialty societies submitted updated paid invoices for supply items SD247 *human amniotic membrane allograft* and SD248 *human amniotic membrane allograft mounted on a non-absorbable self-retaining ring*. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

#### **Work Neutrality**

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

#### **Neuromuscular Ultrasound (Tab 19)**

**Lauren Nicola, MD (ACR), Andrew Moriarity, MD (ACR), Carlos Milani, MD (AAPMR), Brooke Bisbee, DPM (APMA), Timothy Laing, MD (ACR) and Kevin Kerber, MD (AAN)**

In October 2021, the CPT Editorial Panel created CPT category I code 76883 to describe 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. These coding changes went into effect for CPT 2023. 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. Based on 2020 Medicare claims data, rheumatology was the top provider for 76881 (25.7% of global and -26 Medicare claims across all sites). For rheumatology, physicians typically scan patients with portable ultrasound devices rather than utilizing sonographers. Based on Medicare 2020 claims data, radiology was the dominant physician provider for 76882 (57.3% of global and -26 Medicare claims across all sites) and typically performs examinations with preliminary ultrasound scanning by a sonographer and additional imaging performed by the physician. However, at its January 2022

meeting, 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 professional component for CPT code 76882 (global + -26 reporting), the radiologist was the dominant provider for physician work at all sites of service; however, for the technical component (TC) in the non-facility setting (non-facility global and -TC reporting), which determines the top specialty for non-facility practice expense inputs, Podiatry was the top specialty. Thus, the radiology inputs were removed from the PE for code 76882 because podiatry was the top provider, and there were no sonographers included in the PE inputs as the physician performs the image acquisition instead.

In the Medicare Physician Payment Schedule Final Rule for CY 2023, CMS requested that the RUC and other interested parties reconsider the practice expense inputs for the neuromuscular ultrasound family codes 76881, 76882 and 76883 in the near term. In reviewing the comments posted at regulations.gov, CMS received 300+ form letters from rheumatologists objecting to the proposed practice expense payment reductions. This objection was not included in the letter from the American College of Rheumatology to CMS. This issue was placed on the level of interest for review at the January 2023 meeting.

As part of its deliberations, the PE Subcommittee reviewed a letter submitted by the six relevant specialty societies and an updated PE spreadsheet with recommended inputs appropriate for each of the three codes based on the current and projected utilization. The PE Subcommittee discussed the transitory nature of who is the typical provider amongst the multiple specialties which perform these services. The Subcommittee concurred that the most recent, 2021 Medicare utilization data, reflects the following top specialties providing the service in the global + TC non-facility setting: 76881 Rheumatology (26%), 76882 Radiology (27%) and 76883 Neurology are anticipated to be the top performing non-facility providers of the service. The PE Subcommittee agrees with the specialties' assertion that the top specialty for CPT code 76882 now accurately reflects service by radiology, which has been the historical standard and was temporarily changed to podiatry based on COVID pandemic alterations of the utilization. Additionally, utilization of 76883 should be greater among non-radiology specialties which will decrease their relative utilization of 76882. It was further noted that compelling evidence would be met for code 76882 given that there is evidence that previous practice expense inputs were based on one specialty, but that service is currently provided primarily by physicians from a different specialty according to utilization data.

The PE Subcommittee reviewed the practice expense recommendations for this code family and approved the inputs with two modifications to CPT code 76882. Three minutes were removed from CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* to match 76881 as both codes are typically reported with an Evaluation & Management (E/M) service in the non-facility on the same day over 50%. The cleaning supplies were also updated for code 76882 for consistency across the code family. The inputs for CPT codes 76881 and 76883 were unchanged from January 2022. In addition, the Subcommittee agreed with the use of clinical labor staff type L050B *Diagnostic Medical Sonographer* for code 76882 since radiology has been reinstated as the top specialty. For this reason, the use of ED050 *Technologist PACS workstation* and ED053 *Professional PACS workstation* was deemed typical for code 76882 only. The use of EQ250 *ultrasound unit, portable*, not a hand-held unit or ultrasound room, was deemed to be most appropriate and typical for the equipment inputs across the code family. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee for CPT code 76882. In addition, the RUC recommends that a PC/TC split be applied for CPT codes 76881, 76882 and 76883.**

### **New Technology**

In January 2022, CPT code 76883 was placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions. It was explicitly noted that the other codes in the family, CPT codes 76881 and 76882, should also be reviewed at that time.

### **Remote Interrogation Device Evaluation – Cardiovascular (Tab 20)**

**Richard Wright, MD (ACC), Ed Tuohy, MD (ACC) Mark Schoenfeld, MD (HRS) and David Slotwiner, MD (HRS)**

In January 2017, the RUC reviewed the work and practice expense (PE) for codes 93297 and 93298 as part of the Cardiac Electrophysiology Device Monitoring Services code family. Subsequently, based on issues identified in the Proposed Rule for CY 2018, the RUC again reviewed the direct practice expenses only for 93297 and 93298 at the October 2018 RUC meeting. Additionally for CY2020, CMS created and implemented practice expense only code G2066 *Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results* as contractor-priced rather than adopt the direct practice expense inputs put forward in a separate CPT code, 93299 *Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results*. In February 2019, the CPT Editorial Panel deleted CPT code 93299 (effective CPT 2021), as it was no longer necessary to have a separate code for practice expense once CPT codes 93297 and 93298 were allocated direct practice expense inputs in 2020.

In April 2022, the Relativity Assessment Workgroup (RAW) identified G2066 as a contractor-priced service with 2020 Medicare utilization over 10,000. In September 2022, the specialty societies requested that the RAW reaffirm its 2018 approved PE inputs for 93299 and recommend that they be used to establish national pricing for G2066. However, CPT code 93299 was deleted in 2021. Therefore, code G2066 was referred to the RUC for review at the January 2023 RUC meeting.

### **Affirmation of RUC Recommendations**

In January 2023, the RUC recommends affirming the January 2017 RUC recommendations for CPT codes 93297 *Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU = 0.52) and 93298 *Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU = 0.52), previously submitted for the CPT 2018 cycle.

### **Practice Expense**

The RUC reviewed the direct practice expense inputs for CPT codes 93297 and 93298 and agreed with the specialty societies to change the clinical staff allocation for CA021 *Perform procedure/service---NOT directly related to physician work time* from L037A *Electrodiagnostic Technologist* to L038B *Cardiovascular Technician*. The PE Subcommittee discussed that since these codes are reported monthly, the 11 minutes for education/re-education should be reduced. The PE Subcommittee reduced the education/re-education from 11 minutes to 4 minutes, therefore totaling 69 minutes for CPT codes 93298 and G2066 and 33 minutes for CPT code 93297 for CA021 *Perform procedure/service---NOT directly related to physician work time*. Consequently, the equipment time was also reduced by 7 minutes for EQ198 *pacemaker follow-up system (incl software and hardware)*

(*Paceart*). The RUC recommends the same direct practice expense inputs for G2066 as CPT code 93298 since they are the same type of monitoring. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

#### **New Technology/New Services**

In October 2018, CPT codes 93297 and 93298 were reviewed and placed on the new technology/new services list for review by the Relativity Assessment Workgroup in April 2024. CMS did not accept the practice expense for these services and instead created G2066 to report the practice expense associated with these services. **Since the RUC affirmed the work RVUs and recommended direct PE inputs for codes 93297, 93298 and G2066 at this meeting, the RUC requests that these services be placed back on the new technology/new services list to assess the work and practice expense in 3 years (April 2027).**

### **XI. Research Subcommittee (Tab 21)**

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

The Research Subcommittee did not have a general policy meeting which coincided with the January 2023 RUC meeting. The Subcommittee had last met on October 3, 2022, to review specialty society requests pertaining to RUC surveys for the January 2023 meeting. On the October 3rd call, the Research Subcommittee reviewed and approved proposed vignettes, custom survey templates, survey educational materials, and a targeted survey sample methodology.

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

### **XII. Practice Expense Subcommittee (Tab 22)**

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

In April 2022, the RUC determined that the Practice Expense (PE) Subcommittee should further review the issue of skin adhesives, specifically Dermabond, after accepting the use of SG007 *adhesive, skin (Dermabond)* as part of the Neurostimulator Services-Bladder Dysfunction tab. The PE Subcommittee created a Skin Adhesives Workgroup that reviewed the issue of skin adhesives, focusing on wound closure, and identified several generic alternatives to Dermabond. The PE Subcommittee discussed that the use of Dermabond is not typical and is only included in two CPT codes and four G codes. The Subcommittee agreed that there are multiple skin adhesive products at different price points available that work similar to Dermabond and noted that the CMS price of \$57.67 does not appear to reflect accurate current pricing. The Subcommittee further determined that generic alternatives should be used overall in place of brand names. The RUC agreed with the following recommendations of the PE Subcommittee:

- 1. The PE Subcommittee review the six codes on the Medicare Payment Schedule with Dermabond (64590, 64595, G0168, G0516, G0517, G0518) to identify justification for its use versus the generic version and present its findings to the RUC for approval. As part of this review, the specialty should submit a letter to the RUC regarding any corrections to the vignettes for CPT codes 64590 and 64595.**
- 2. The PE Subcommittee request that the RUC recommend to CMS that Dermabond be replaced with its generic cyanoacrylate skin adhesive alternative on the CMS Direct PE Inputs Medical Supplies Listing.**

3. **The PE Subcommittee request that the RUC recommend to CMS that new medical supply item codes be created to encompass the generic formulations of cyanoacrylate skin adhesive in multidose form and single use sterile application.**
4. **The PE Subcommittee request that the RUC recommend to CMS that generic alternatives be used in place of brand names on the CMS Direct PE Inputs Medical Supplies Listing.**

The PE Subcommittee also discussed the ongoing issue of high-cost supply items as several tabs at this meeting contained new expensive supplies. **The Subcommittee requested, and the RUC agreed, that the RUC recommend that CPT consider including a question on high-cost disposable supplies on its Coding Change Application (CCA).** It is important for the CPT Editorial Panel to understand if a high-cost supply (eg, >\$500) may warrant a discussion regarding its implication on coding. The PE Subcommittee also emphasized its continued support for the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes due to the impact on the indirect practice expense RVUs and the ability to appropriately update the cost on a more frequent basis.

During discussion of Tab 07 Posterior Nasal Nerve Ablation, **the PE Subcommittee suggested that the RUC recommend to CPT that a CPT Assistant article be created for CPT code 30117** to address the number of typical units of service performed on the same date which should be 1 moving forward not 2, and also to address possible inappropriate coding. **Absent discussion, this request was transmitted to CPT staff.**

At the April 2023 meeting, the PE Subcommittee will consider the following two items that were discussed under New Business: Post-Operative Patient Communications and Pricing of Packs.

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

### **XIII. Health Care Professionals Advisory Committee (HCPAC) Review Board (Tab 23)**

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

The HCPAC Review Board conducted an election for the positions of Co-Chair and Alternate Co-Chair at their January 2023 meeting. **The HCPAC elected Richard Rausch, DPT, Co-Chair and Leisha Eiten, AuD, Alternate Co-Chair. The new terms for both positions will begin March 1, 2023, and conclude in February 28, 2025.**

The HCPAC Review Board reviewed the addition of CPT codes 99222 and 64455 to the HCPAC Multi-Specialty Points of Comparison (MPC) list that were on the consent calendar. **The HCPAC voted to accept the addition of CPT code 99222 and 64455 to the HCPAC MPC list.**

**The RUC filed the HCPAC report as presented.**

### **XIV. Relativity Assessment Workgroup (Tab 24)**

Doctor John Proctor, Chair, provided the Relativity Assessment Workgroup (RAW) to the RUC. Doctor Proctor indicated the RAW reviewed two action plans.

**Different Performing Specialty from Survey**

**Acupuncture/Electroacupuncture (97810-97814)**

In September 2022, the Relativity Assessment Workgroup identified these services with 2020 Medicare utilization over 10,000 where the service was surveyed by one specialty but is now performed by a different specialty. These services were surveyed by the American Chiropractic Association in April 2004. The Workgroup noted that Medicare does not cover these services when reported by chiropractors. Hence, the Medicare utilization data does not include these services when provided by chiropractors. The Workgroup confirmed that chiropractors were involved in the action plan and will be part of the level of interest and survey process. **The Workgroup reviewed the January 2023 action plan and agreed with the specialty societies that codes 97810-97814 should be surveyed for April 2023.**

**Work Neutrality CPT 2018 (95249-95251)**

**Ambulatory Continuous Glucose Monitoring (95249-95251)**

In February 2017, the CPT Editorial Panel revised 95250 & 95251 and created a new code to differentiate between physician owned and patient owned equipment. In June 2017, the CPT Editorial Panel 1) Revised the parenthetical note following code 95249 to instruct that 95249 should not be reported more than once for the duration that the patient owns the data receiver; 2) Added guidelines that state when data are collected outside the provider office, as when the patient uses a phone app, code 95249 may not be reported; and 3) Indicated that instruction be provided immediately when the equipment is owned by the patient. In October 2019, the RUC identified this family as having more than 10% increase (65%) in work RVUs for 2018 than what was projected. The Workgroup noted that these services decreased in work RVUs for 2018 but due to the high utilization increase for 95251 there was no work savings. The Workgroup agreed with the specialty societies that the volume increase appeared appropriate due to the increase in diabetic population and the effectiveness of the patient owned continuous glucose monitoring subcutaneous sensor. The Workgroup recommended reviewing an action plan in 3 years (January 2023) by examining the relationship between 95250 and 95251 and the prevalence of patients owning their own device (see code 95249).

In January 2023, Workgroup agreed that there has been a change in guidelines and the utilization growth is clinically appropriate with continuous glucose monitoring more effective in maintaining control of hyperglycemia than traditional fingerstick glucose monitoring. **The Workgroup agreed with the specialty society that codes 95249-95251 be removed from the work neutrality screen.** The Workgroup noted if the growth continues, this will be seen on the high volume growth screen and be examined in the future.

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 the Relativity Assessment Workgroup report as presented. The full report is attached to these minutes.**

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

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

**Review of Consent Calendar – Reinstatement of Codes to MPC List**

The MPC workgroup reviewed a consent calendar prepared by AMA staff consisting of 18 codes pending reinstatement to the MPC list which were temporarily removed until after CMS finalized

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their valuation. **The MPC Workgroup recommends reinstating the following 18 services: 28003, 77002, 90460, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99285, 99304, 99306, 99308, 99309 and 99310.**

#### **MPC List Services Additions**

The MPC Workgroup members also reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list, which tallied codes in consideration for addition to the MPC list from six participating specialty societies. **The MPC Workgroup recommends adding the following 6 services: 22630, 22632, 22633, 22634, 27446 and 27447.**

#### **Other Business**

The Workgroup requests that for future applications for changes to the MPC, more granular rationale be developed and provided by the specialty society. The specialty society should respond to each of the absolute and suggested criteria in their recommendation, formatted with a checkbox, an area for rationale and previous history of both the RUC and CMS valuation of the service.

The Workgroup also discussed the suggested criteria, and it was noted that for low utilization codes, the specialty should follow the guidelines and provide support if Medicare utilization is less than 1,000 or not yet available. It was also suggested that the Workgroup may wish to re-order the process document, and specifically to list the suggested criteria in an order that reflects a ranking of importance.

A Workgroup member questioned what it means that all parties (specialty society, RUC, and CMS) accept the published valuation. It was clarified that in order for the RUC to accept a CMS modified value, the specialty would need to request that the RUC to affirm the current CMS published value. **The RUC approved the Multi-Specialty Points of Comparison Workgroup report as presented. The full report is attached to these minutes.**

### **XVI. Rotating Seat Elections (Tab 26)**

#### **Administrative Subcommittee**

Doctor Margie Andreae, Chair, indicated that the Subcommittee reviewed and approved the two candidates for the rotating seats. The elections occurred Friday, January 13, 2023.

David Han, MD, Society for Vascular Surgery (SVS), was elected to the RUC's Any Other rotating seat.

Omar Hussain, DO, American Thoracic Society (ATS)/ American College of Chest Physicians (CHEST), was elected to the RUC's Internal Medicine rotating seat.

The term for the rotating seats is two years, beginning in March 2023 and ending in February 2025 with the provision of final recommendations to CMS.

### **XVII. New Business (Tab 27)**

- Departing RUC member, Alan Lazaroff, MD, remarked that the RUC's collegiality and the integrity of the process and deliberations have improved over the years. RUC members thanked Doctor Lazaroff for his important contributions to the RUC process.

- A RUC member inquired about adding an additional question to the RUC survey to expand beyond the typical site-of-service. The expanded question would inquire if the respondents perform the service in each of the settings. Another member further clarified that the Summary of Recommendation (SOR) document should be updated to include the word “typical” to match question 2C on the 010-day and 090-day surveys. Additionally, it was discussed that site-of-service questions should also be incorporated in the 000-day global survey to reflect the typical site of service. **This item has been referred to the Research Subcommittee.**
- A RUC member requested general guidelines/guidance for the use of crosswalk codes to support valuation recommendations. Several RUC members supported this request. **This item has been referred to the Research Subcommittee.**
- A RUC member requested that instructions related to developing recommendations for services performed in the non-facility setting be included in the Practice Expense Instructions. These instructions should confirm that Specialties determine if non-facility inputs should be developed for new/revised/family CPT codes for issues on the RUC agenda. For existing CPT codes without non-facility direct practice expense inputs, CMS may request the development of inputs via rulemaking. Through the RUC level of interest process, PE review shall be scheduled accordingly.
- A RUC member emphasized the continuation of advocating for the removal of high-cost disposable supply items from direct input recommendations. Several RUC members expressed continued support for the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. Further, a member inquired about why CMS does not review the inputs for high-cost supply items on a regular basis as some codes were valued 5-10 years ago and have maintained their expensive supply inputs. It was noted that the RUC should request that CMS amplify its review process and utilize HCPCS codes.
- A RUC member requested the addition of a question regarding national and Medicare utilization in the PE SOR, specifically for PE only codes. AMA staff will add the question to the PE SOR, per the RUC’s request.
- A RUC member requested that pre-facilitation be re-evaluated to determine how the RUC should proceed with executing the meeting post-COVID. During the discussion, it was determined that pre-facilitation is an important component leading up to the RUC meeting to provide guidance to, and answer questions for, the specialty societies prior to their presentation to the RUC. To prevent unnecessary pre-facilitation, reviewers should note via email or in reviewer comments if they do not think a given tab requires pre-facilitation. If the specialties agree, AMA staff will remove the tab from pre-facilitation.

The RUC adjourned at 11:08 AM ET on Saturday, January 14, 2023.