AMA/Specialty Society RVS Update Committee
Loews Coronado Bay Resort, Coronado, CA
January 17-20, 2024

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in January 2024. Doctor Ezequiel Silva, III, called the meeting to order on Friday, January 19, 2024, at 9:15 a.m. PT. 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
Gregory L. Barkley, MD
James Blankenship, MD, MHCM
Robert Dale Blasier, MD
Audrey Chun, MD
Joseph Cleveland, MD
Gregory DeMeo, DO
William Donovan, MD, MPH
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
David Han, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
Omar Hussain, DO
M. Douglas Leahy, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
Swati Mehrotra, MD
John Proctor, MD
Richard Rausch, DPT, MBA
Kyle Richards, MD
Lawrence Simon, MD
Michael J. Sutherland, MD
Donna Sweet, MD
James C. Waldorf, MD
Thomas J. Weida, MD
Adam Weinstein, MD

RUC Alternates:
Jennifer Aloff, MD
Gregory L. Barkley, MD
Eileen Brewer, MD
Neal Cohen, MD
Neeraj Desai, MD
Leisha Eiten, AuD
William Gee, MD
Patrick Godbey, MD
Martha Gray, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kris Kimmell, MD
Charles D. Mabry, MD
Mollie MacCormack, MD
John McAllister, MD
Michael Perskin, MD
Sanjay Samy, MD
James L. Shoemaker, MD
Matthew Sideman, MD
Clarice Sinn, DO
Timothy Swan, 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.

- Doctor Silva communicated the following guidelines related to confidentiality:
  - All attendees shall respect our confidentiality provisions indicated in the agreement to which you attested via the registration process.
  - Confidentiality requirements extend to both materials and discussions at this 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.
  - The full lobbying policy can be found on the 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 welcomed the Centers for Medicare & Medicaid Services (CMS) attendees:
  - Perry Alexion, MD
  - Hannah Ahn
  - Arkaprava Deb, MD
  - Morgan Kitzmiller
  - Michael Soracoe

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

- Doctor Silva welcomed the following Members of the CPT Editorial Panel:
  - Lawrence Simon, MD – CPT Editorial Panel Member
  - Timothy Swan, MD – CPT Editorial Panel Member

- Doctor Silva welcomed the following Member of the AMA Board of Trustees:
  - Willie Underwood III, MD, MSc, MPH – Chair

  - Doctor Underwood thanked the RUC, stating that "all the effort and commitment that you must do to prepare for this meeting, and the expertise and the depth of knowledge that is required just to understand the volume of information that is provided and utilized during this process. It leaves me speechless. So having said that, I would like to thank you, all of you, for all your commitment to this process and for the decades that many of you have put into this and preparing for this. And those of you who are just joining, I want to thank you for the future decades that you are going to put into this. And I do that on behalf of the AMA, on behalf of healthcare overall, and for our society."

- Doctor Silva welcomed the following observer from the Alberta Medical Association:
  - Jim Huston – Assistant Executive Director

- Doctor Silva recognized the departing RUC members:
  - William Donovan, MD (ACR)
  - Marc Raphaelson, MD (AAN)
  - Donna Sweet, MD (Primary Care Rotating Seat)
  - Adam Weinstein, MD (RPA)
  - David Wilkinson, MD (CAP)

- Doctor Silva recognized the new RUC members:
  - Gregory Barkley, MD (AAN)
  - Swati Mehrotra, MD (CAP)

- Doctor Silva recognized the new RUC alternate members:
  - Kevin Kerber, MD (AAN)
  - Patrick Godbey, MD (CAP)

- 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)
    - Moderate Sedation

- 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 for the RUC:
  - 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 that all 29 votes can be accounted for.
- 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 the process for reviewing Administrative Subcommittee recommendations:
  - Reviewed the rotating seat policies and election rules.
  - Reviewed and approved the nominations for the Internal Medicine and Primary Care rotating seats.
  - The Administrative Subcommittee Report was approved.

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 recognized the reappointments:
  - Peter Hollmann, MD – AMA RUC Member (Vice-Chair)
  - Robert Zwolak, MD – AMA RUC Alternate Member

- Ms. Smith conveyed the following information regarding the Physician Practice Information (PPI) Survey Update:
  - The PPI Survey was fully launched in late 2023 by Mathematica and the American Medical Association.
  - Approximately 1200 practices have initiated the survey to date. Approximately 200 have completed the survey.
  - The AMA will be preparing reports to summarize the number of practice surveys completed, along with the number of physicians represented in each practice, by specialty.

  - AMA is enhancing communications and considering other mechanisms to make certain physicians understand that their practice may be invited to participate. All communications to raise awareness are appreciated.
  - Mathematica is also conducting the PPI Survey for non-MD/DO qualified health care professionals and the independent diagnostic testing facility (IDTF) community. Those surveys will be initiated in late January or early February 2024.

- 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 the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches 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 2022 Medicare claims data.

- 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 by clicking "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 2026 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Apr 2, 2024	Apr 24-27, 2024	Chicago, IL	CPT 2026
Aug 27, 2024	Sept 25-28, 2024	Washington, DC	CPT 2026
Dec 10, 2024	Jan 15-18, 2025	Anaheim, CA	CPT 2026

IV. Approval of Minutes from the September 2023 RUC Meeting

The RUC approved the September 2023 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update

Lawrence Simon, MD, CPT Editorial Panel Member, provided the following CPT Editorial Panel update on the CPT Editorial Panel Composition, CPT Ad Hoc Workgroups, and upcoming CPT meeting:

- New CPT Editorial Panel Members
  - Christopher L. Jagmin, MD – Panel Chair
  - Barbara S. Levy, MD – Panel Vice-Chair

  - Sarah Abshier, DPM
    - Specialty: Podiatry
  - Mark Bailey, DO, PhD
    - Specialty: Neurology & Pain Medicine
  - Leo Bronston, DC, MAppSc
    - Specialty: Chiropractic
  - Steven Hao, MD
    - Specialty: Cardiology
  - Craig Kliger, MD
    - Specialty: Ophthalmology
  - Kathy Jones, MD
    - Specialty: Urogynecology
  - Lori Moore, PharmD
    - CDC Liaison
  - Douglas Kelly, MD
    - FDA Liaison
  - The CPT Editorial Panel consists of 21 members.

- February 2024 CPT Editorial Panel Meeting
  - 40 items of business
    - Notable agenda items:
      - 5 Digital medicine related Coding Change Applications (CCAs)
      - 11 Category III code applications
      - 1 RUC referral to CPT
    - The Panel considered and discussed the following notable items:
      - Online Digital Evaluation and Management-New and Established Patients
      - Endovascular Therapy Bundling-Revise 61624, 61626
      - Maternity Care Services
      - Prostate Biopsy Services
      - Hearing Device Services
      - Qualified Health Care Professional (QHP) Terminology Standardization
      - Code Set Maintenance

- CPT Ad Hoc Workgroups
  - Tumor Genomics Neoplastic Targeted Genomic Sequencing Procedures (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 GSP Workgroup began its work shortly after the May 2023 meeting.
    - The work has been divided into two subgroups as follows:
      - Subgroup A – Co-Chairs: Aaron Bossler, MD, Madhuri Hegde, MD
      - Subgroup A is assigned the following charge:

        - (1) Modification of code 81443 (Genetic testing for severe inherited conditions) and/or development of new code(s) to address current practice for Expanded Genetic Disease Carrier or Diagnostic Panel Testing; and
        - (2) Development of a code(s) for a Basic Genetic Disease panel (CFTR, FMR1, SMN1/2, HBB) Panel Testing.
    - Subgroup B – Co-Chairs: Lawrence Simon, MD, Lawrence Jennings, MD
    - Subgroup B is assigned the following charge:
        - (1) Modification of codes 81435 and 81436 (Genetic testing for hereditary colon cancer disorders) and/or development of new code(s) to address code stacking when testing for Lynch Syndrome; and
        - (2) Development of a code(s) for Pan-Cancer Disorders testing.
    - Next steps for the workgroup are for the Subgroups and stakeholders to finalize proposed language and continue gathering supporting documentation for CCA submission for the May 2024 Panel meeting.

- Digital Medicine Coding Committee (DMCC)
    - Co-Chairs: Richard Frank, MD, PhD/Mark Synovec, MD
    - Workgroup Charge: This advisory group to the CPT® Editorial Panel (Panel) shall be known as the Digital Medicine Coding Committee (DMCC). The charge of the DMCC is to respond to requests from the Panel and to support the Panel on coding issues that involve or may include a digital medicine and/or an artificial intelligence component by providing or obtaining expertise or advice on a specific subject matter. At all times, the Panel shall have the sole authority to create, revise and update codes, descriptions, and applicable guidelines for appropriate CPT coding.
    - The co-chairs are currently reviewing nominations and will possibly have their first public virtual meeting in March 2024.

- Upcoming CPT Editorial Panel Meetings
    - The next Panel meeting is February 1-3, 2024 (Thursday-Saturday) – San Diego, CA
    - Annual CPT Health Care Professionals Advisory Committee (HCPAC) Meeting – Thursday, February 2. Topics include:
        - U.S. Food and Drug Administration (FDA) Overview
        - CPT Technology Update
        - CPT Information Services (IS) Update
        - Confidentiality Policy: An Overview
        - CPT Volume Criteria – Open Discussion
    - The next application submission deadline is February 5, 2024.

VI. Centers for Medicare & Medicaid Services Update

Perry Alexion, MD, Medical Officer, provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the CY 2024 Medicare Physician Payment Schedule (MFS) Proposed Rule.

- CMS 2024 Final Rule
    - On November 2, 2023, 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, 2024.
    - The Physician Fee Schedule (PFS) final rule announced policy changes for Medicare payments under the PFS for CY 2024. In addition to the final CY 2024 PFS payment rates, the final rule included:
        - Policies aiming to advance health equity under Medicare Part B;
        - Helping patients navigate cancer treatment and treatment for other high-risk conditions;
        - Providing for Medicare Parts A and B payment for certain dental services and closely examining the relationship between dental services and certain kinds of cancer treatment;
        - Expanding access to behavioral health services through the implementation of key provisions authorized by Congress;
        - Adopting the office/outpatient evaluation and management visit complexity add-on code to improve payment for primary and longitudinal care;
        - Continuing Public Health Emergency (PHE) flexibilities under the Medicare Diabetes Prevention Program (MDPP) Expanded Model; and
        - Updating the Medicare Shared Savings Program and the Quality Payment Program.

- CMS 2024 Proposed Rule Highlights
    - CY 2024 PFS Rate-Setting/Conversion Factor
    - Evaluation and Management (E/M) Services
    - Behavioral Health Services
    - Dental and Oral Health Services
    - Telehealth Services
    - Caregiver Training Services
    - Social Determinations of Health (SDOH) Risk Assessment
    - Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

- Additional Updates
    - CMS is developing sub-regulatory guidance, including Medicare Learning Network (MLN) and Frequently Asked Questions (FAQs) Material for certain policies finalized for CY 2024.
    - Potential for legislative changes to CY 2024 PFS payment.
    - Recent changes in leadership were reviewed.

- Doctor Alexion addressed questions from attendees:
    - A RUC member inquired about CMS projections on the effect of the newly implemented E/M visit complexity add-on code G2211 on the conversion factor over the next few years. Doctor Alexion referred the question to his colleague, Michael Soracoe, and they responded that the specific details of G2211 and the effect on budget neutrality are detailed in the CY 2024 Final Rule.
    - A RUC member thanked the administration for recognizing and implementing payment to address social determinants of health (SDOH).

VII. Contractor Medical Director Update

Janet Lawrence, MD, MS, FACP Noridian Contractor Medical Director (CMD), Noridian Healthcare Solutions, LLC, provided the CMD update.

- New Coverage – Physician Final Rule
  - Community Health Integration (CHI) services
    - HCPCS codes G0019 and G0022
  - Principal Illness Navigation (PIN) services
    - HCPCS codes G0023, G0024, G0140, and G0146
  - Social Determinants of Health (SDOH)
    - HCPCS code G0136
  - Caregiver Training
    - CPT codes 96202, 96203, 97550, 97551, and 97552

- Acupuncture for Chronic Low Back Pain (CLBP)
  - CR13288
  - Implementation date: 1/2/2024
    - National Coverage Determination (NCD) 30.3.3 – updated frequency edits
    - Relevant codes for acupuncture and dry needling services
      - 97810, 97811, 97813, 97814, 20560, and 20561
    - One session = one initial acupuncture (97810 or 97813) with or without variation
      - CPT add-ons (97811 or 97814) on same date of service
    - Dry needling – either CPT 20560 or 20561 on same date of service; not both

- Beta Amyloid PET in Dementia and Neuro Disease
  - CR13429
  - Implementation date: 12/19/2023
  - NCD 220.6.20 - Beta amyloid Positron Emission Tomography (PET) in dementia and neurodegenerative disease
  - CMS removed NCD and deactivated edits
    - Ending coverage with evidence development (CED) for PET beta amyloid imaging
    - Dates of service on and after 10/13/2023

- Chemotherapy Administration
  - CR13468
  - Complex administration
    - CPT codes 96401-96549
    - Involves monoclonal, complex biological, and rheumatological therapies
    - Must meet all elements required for appropriate billing
    - Internet only manuals (IOM) 100-04, Chapter 12, Section 30.5

- Upcoming Local Coverage Determinations (LCDs)
  - LCDs
    - Amniotic Products, Non wound
    - Microinvasive Glaucoma Surgery (MIGS)
    - Botox
    - Trigger points

        - Cervical Fusion
        - Facet

- Medicare Administrative Contractor (MAC) CMD Workgroup Activity
    - Lots of new CMDs
    - Continuing to Collaborate
    - New CMD training led by National Government Services, Inc. (NGS) and Celerian Group (CGS) Administrators, LLC

- Molecular Diagnostic Services (MOLDX) Program Expands to Cover Proteomics
    - Pending new LCD requests in the waitlist
        - Kidney Neoplasm
        - Tumor Immune Microenvironment
        - Heritable thoracic aortic disease (HTAD)
        - Hereditary transthyretin amyloidosis (hATTR)
        - Renasight™ Kidney Gene
        - Plasma microbial cell-free (mcf)DNA sequencing
        - AVISE® Lupus

- MOLDX – New LCD Requests and Reconsiderations
    - New LCD requests in progress
        - Prelude™ diagnosis
    - Pending Reconsideration requests in waitlist
        - BCR-ABL (genetic testing) policy
        - DetermaRx™ (Formerly Razor Genomics 14-Gene Lung Cancer Assay) L38238
        - Oncuria® for Lab: Bladder/Urothelial Tumor Marker
    - Reconsideration requests in progress
        - Knodule ID for BDX-XL2

- Drafted MOLDX Policies
    - Policies taken 07/17/23 Open Meeting
        - MolDX: Molecular Biomarker Testing for Risk Stratification of Cutaneous Squamous Cell Carcinoma DL39583
    - Policies taken to 09/18/23 Open Meeting
        - MolDX: Molecular Testing for Solid Organ Allograft Rejection DL38568
    - Policies taken to 10/09/23 Open Meeting
        - MolDX: Molecular Testing for Risk Stratification of Thyroid Nodules DL39646
        - MolDX: Molecular Biomarkers for Risk Stratification of Indeterminate Pulmonary Nodules Following Bronchoscopy DL39654
        - MolDX: Gene Expression Profile Tests for Decision-Making in Castration Resistant and Metastatic Prostate Cancers DL39636

- Telehealth – Teaching Physicians Through 2024
    - Teaching physicians may use audio and video real-time communications.
        - When resident furnishes Medicare telehealth services.
        - Approved all residency training locations.
    - Define direct supervision to permit presence and “immediate availability” of supervising practitioner through real-time audio and visual interactive telecommunications.

- Removal of frequency limitations of Subsequent Inpatient Visit, Subsequent Nursing Facility Visit, and Critical Care Consultation codes.
- Telephone evaluation CPTs 99441-99443 and 98966-98968.

- Dental Services Expansion 2024
  - 2024 Additional Exceptions to Statutory Exclusion of Dental Services
    - In January 2024, Medicare Part A/B will pay for certain dental services that are inextricably linked to the clinical success of other medically necessary and covered services used to treat cancer, prior to, or contemporaneously with:
      - Chemotherapy services that cause immunosuppression and which may lead to significant oral complications and adverse events that might compromise the success of the primary medical procedures and treatments;
      - Chimeric Antigen Receptor T (CAR-T) Cell therapy; and,
      - Use of high-dose bone modifying agents (antiresorptive therapy) when used in the treatment of cancer.

  - 2024 Head and Neck Cancer Associated Dental Services
    - Beginning 2024, CMS will permit Part A/B payment for:
      - Dental or oral examination performed as part of a comprehensive workup prior to, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, and medically necessary diagnostic and treatment services to address dental or oral complications after, radiation, chemotherapy, and/or surgery when used in the treatment of head and neck cancer.

  - Details
    - Payment made under the applicable payment system for both Parts A and B.
    - Dental services can occur over multiple visits.
    - Inpatient or outpatient setting.
    - Must be "PRIOR TO" Medicare covered procedure or service (organ transplant or cardiac valve)*
      - *Except when related to head and neck cancer treatment (i.e. status post radiation, chemo, surgery)
    - Dental provider must be enrolled in Medicare or meeting "incident to" requirements under a Medicare enrolled physician.
    - Contractor pricing.

  - High Dose Bisphosphonate Therapy Definition
    - Refers to the usage of bisphosphonate therapy when used in the treatment of cancer as per FDA label.
    - Intravenous (IV) bisphosphonate therapy for the treatment of multiple myeloma and bone metastases of solid tumors as stated on FDA label.
    - No coverage for oral regimens or if bisphosphonates were prescribed for other diagnoses (such as osteoporosis or Paget's disease alone).

  - Inextricably Linked
    - Dental services that are *inextricably linked to,* and *substantially related and integral to the clinical success of*, a certain covered medical service.
      - Clinical success and outcomes dependent upon these services:

- Integration between health care professionals is required; and
- Supported by clinical evidence.

- Integration of Health Care Professionals
  - Dental service provider must demonstrate exchange of information between them and the medical professional (physician or other non-physician practitioner) *performing the primary medical service.*
  - Can occur in various forms such as:
    - Referral; or
    - Exchange of information between the medical professional (physician or non-physician practitioner) and the dentist.

- Supported by Clinical Evidence
  - Evidence must support provision of these dental services PRIOR TO primary covered medical procedure or service, if not performed, would result in a material difference in terms of clinical outcomes and success of the medical procedure or service:
    - Relevant peer-reviewed evidence-based medical literature.
    - Evidence-based clinical guidelines and/or generally accepted standards of medical care.
    - Please note for head & neck cancer treatment, CMS has allowed payment for certain dental services to address dental or oral complications after radiation, chemotherapy, and/or surgery.
    - *Currently, only inextricably linked exceptions noted for 2023 and 2024 are evidence-based.*

- CY 2024 MFS Final Rule Clarifications
  - Still no evidence to support inextricable link to;
    - Additional cardiac procedures (other than heart valve surgeries and/or replacements)
    - Sickle Cell Disease
    - Hemophilia
    - Chronic auto-immune conditions
    - Diabetes
    - End-stage regnal disease (ESRD)
    - Joint replacements
    - Long term immunosuppressive therapies such as treatment of colitis, Crohn's, Lupus, Multiple Sclerosis, Rheumatoid Arthritis, Sjogren's

- Current Challenges
  - Dental expansion of services by CMS is evolving.
  - MACs are not used to reviewing dental claims billed with CDT codes.
  - Current CMS-1500 or electronic equivalent claim form is not feasible for dental practices.
    - 837D claim form used by dentists.
    - Expectation is seeing increased claims billed by dentists and oral or oral-maxillofacial surgeons.
      - Currently seeing some "dental claims" billed by NPs, PAs, and primary care providers.

        - Many come from beneficiaries for dentists that neither enroll in Medicare nor opt out of Medicare.
    - CMS does not allow auto-denials or editing put in place.
    - MACs can auto pay a claim.
        - To deny must do individual claim review.
    - Contractor discretion results in inconsistency of claim reviews, payment and pricing amongst MACs.

- Artificial Intelligence (AI) Workgroup
    - Workgroup on AI
    - More than 500 devices approved by FDA
    - No NCDs or LCDs on AI yet
    - Transitional Coverage for Emerging Technologies (TCET) may assist in facilitating.

- Place of Service (POS) 27 – Outreach Site or Street
    - CR13314
        - "Non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and treatment to unsheltered homeless individuals"
        - POS 27 reimburses same as POS home (12)

- CY 2024 Medicare Physician Fee Schedule Final Rule
    - CR13452
    - Evaluation and Management (E/M)
        - Complexity add-on code G2211
            - Requires practitioner-patient relationship with continuing focal point for all healthcare services.
        - Split or shared services follows CPT guidelines
            - Substantive portion = more than half of total time or medical decision-making.

- Telehealth – Physician Final Rule
    - CR13452
    - HCPCS code Q3014 (originating site facility fee) = $29.96
    - Modifier 95 appended to approved telehealth codes:
        - E.g., provider at hospital or clinic and patient is home
        - Outpatient therapy provided via telehealth by physical therapist, occupational therapist, speech language pathologist
    - 2024 Place of Service (POS) – allowed in all locations
        - 02 – Telehealth provided other than in patient's home
        - 10 – Telehealth provided in patient's home *(reimbursed at non-facility rate)*
    - 2024 Telehealth Approved List

- G2211 – Add-on Visit Complexity Code
    - CR13272
    - Implementation date: 1/2/2024
    - Medicare pays separately for visit complexity add-on code G2211
        - Billing provider continues focal point for care related to medical condition (serious or complex condition)

        - Not reimbursed with office or outpatient E/M billed with modifier 25 (CPT codes 99202-99205, 99211-99215)
            - Same patient and same practitioner
        - Does not pay Method II Critical Access Hospital (CAH) on same encounter for type of bill (TOB) 85X

- Skilled Nursing Facility (SNF) Changes
    - CR13271
        - Implementation date: 1/8/2024
        - Consolidated Billing update
            - IOM 100-04, Chapter 6, Section 20.1.1 revised
            - Added marriage and family therapists, and mental health counselors to consolidated billing list of excluded services.

- Update for Blood Clotting Factor Add-On Payments
    - CR13381
    - Implementation date: 4/1/2024
        - Additional diagnosis codes eligible for payment for blood clotting factors
        - Adjustment of certain claims with added codes
            - Deleted HCPCS codes J7191 and J7199
            - Added HCPCS codes J7177, J7178, and J7214

- Behavioral Health Services – Physician Final Rule
    - CR13452
        - Implemented 1/2/2024
    - 2024 adds new providers eligible to enroll with Medicare
        - Marriage and Family Therapist (MFT) or Mental Health Counselor (MHC)
        - Can bill independently for services furnished for diagnosis and treatment of mental illnesses
            - Complete enrollment application electronically or paper
        - Marriage and Family Therapists and Mental Health Counselors FAQs
    - Psychotherapy for Crisis
        - Allowed at 150 percent of fee schedule for non-facility settings
        - CPT codes 90839 and 90840
    - Health Behavior Assessment and Intervention (HBAI)
        - Psychological, behavioral, emotional, cognitive, and social factors
        - CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168
    - CMS delayed "in-person visit every six months" prior to initiating mental health services and subsequent intervals.
    - 12-month requirement still exists.

- Resources
    - CMS Medicare Learning Network (MLN) Resources
        - MLN Publications
            - Medicare Secondary Payer: Don't Deny Services & Bill Correctly
            - Intravenous Immune Globulin Demonstration
            - New Ownership reporting Requirements for Providers Using Form CMS-855A

- Behavioral Health Links
  - Behavioral Health Integration (BHI) Services
    - Incorporates primary care with behavioral health
    - Psychiatric Collaborative Care Model (CoCM)
    - General BHI
  - CMS Psychotherapy for Crisis
  - CMS Opioid Use Disorder Screening & Treatment

- Social Determination of Health (SDOH) Resources
  - CMS Framework for Health Equity 2022-2032
  - CMS Office of Minority Health
  - CMS Improving Collection of SDOH Data Infographic
  - CMS Z-Codes Infographic
  - CDC Social Determinants of Health (SDOH) Maps- Socioenvironmental: Poverty

- Doctor Lawrence addressed questions from attendees:
  - A RUC member requested clarification on diseases that are treated with immunomodulators where there are often complications such as dental disease and confirmed that scenarios such as this would not be covered under the current coverage decision. Doctor Lawrence confirmed that is correct but pointed out that CMS is collecting data on other diseases that may have evidence inextricably linking it to poor treatment outcomes when dental disease is not appropriately treated.
  - A RUC member inquired about obstructive sleep apnea and utilizing a mandibular repositioning appliance for treatment and if that would be considered inextricably linked to optimal treatment outcomes and therefore be eligible for coverage. Doctor Lawrence responded that at this time that is not inextricably linked so it is not currently covered.

VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, provided the Washington report focusing on AMA Advocacy and the AMA response to the Medicare Physician Payment Schedule (MFS) Final Rule, the Medicare Quality Payment Program (QPP), and Prior Authorization.

- **2024 Medicare Physician Payment**

- Medicare Conversion Factor (CF)
  - Starting Jan. 1, 2024, physicians and QHPs face a -3.4% cut to the conversion factor:
    - In 2023 the conversion factor was $33.8872 and the percentage change was negative 2.0%.
    - In 2024 the conversion factor was $32.7442 and the percentage change was negative 3.37.
    - CMS says that the costs to run a medical practice as measured by the Medicare Economic Index will increase 4.6% in 2024.

- AMA and Organized Medicine Advocacy
  - Nov. 16 sign-on letter to Congress: "If Congress does not act by the end of the year to stop this impending payment cut, many physicians will be forced to reduce available health care services, cut office hours, or even forgo treating Medicare patients altogether."

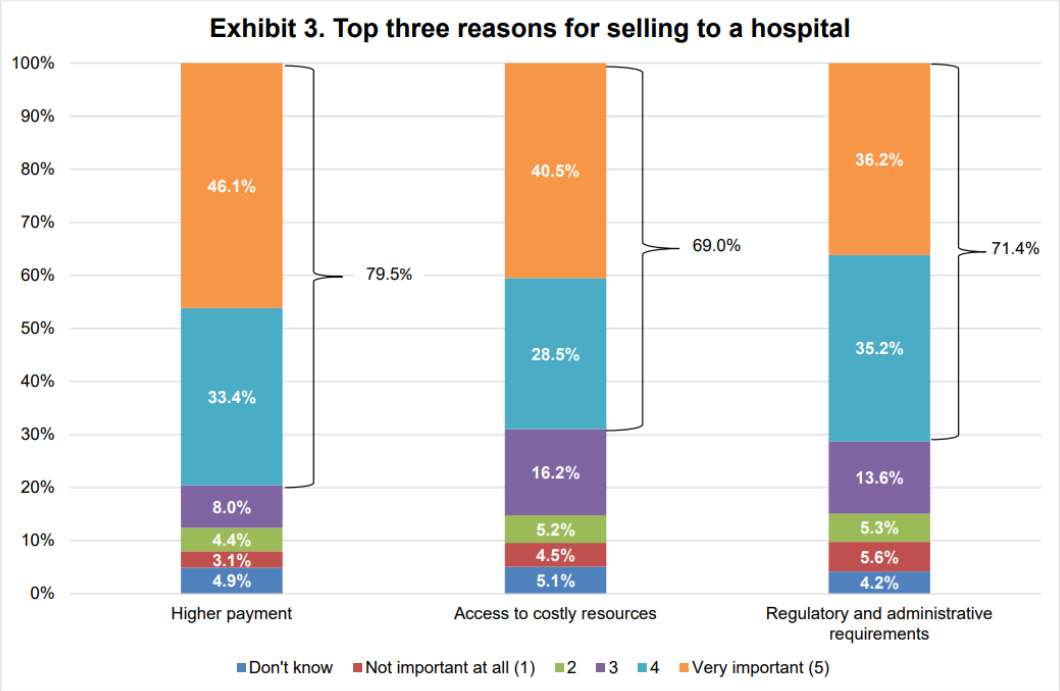
  - Bipartisan bill, Preserving Seniors' Access to Physicians Act bill, H.R. 6683, would eliminate the cut entirely introduced in early December.
  - Nearly 200 Members of Congress urged leadership to prevent the cut
  - Jan. 17 sign-on letter calling on Congress to reverse the cut. "This is our top legislative priority. Physicians are the only Medicare providers that did not receive an inflation update this year. In fact, they are the only Medicare providers who have a payment cut in 2024."

- Short-term spending bill
  - Yesterday, Congress passed, and the President is expected to sign a short-term spending bill that funds the government through early March
  - The law carries forward all the health extenders from the previous stopgap spending measure that passed in Nov.
  - It does not include a fix for the -3.37% cut
  - We will keep fighting!

- AMA: Congress Fails Seniors, Physicians by Ignoring Medicare Cuts
  - "We are disappointed that Congress chose not to stop serious Medicare cuts for physician services in the temporary CR. Failure to reverse these cuts will create access issues for patients and small, independent physician practices, especially those in rural and underserved areas. Physicians are the only providers who have a payment cut this year and now face a nearly 10 percent reduction in Medicare payments over the past four years. Yet, we recognize that Congress' work is far from done and urge lawmakers to reverse these cuts at the soonest opportunity." - Jesse M. Ehrenfeld, M.D., MPH, President, American Medical Association

- Keep up the Pressure
  - Threat of a government shutdown is pushed back to March, but this is no time to let up on the gas
  - 2023 led to the fewest laws in decades
  - Partisan bickering and competing priorities
  - Physician payment is on the table and negotiations are happening now
  - Go to FixMedicareNow.org and urge your lawmakers to stop the -3.37% cut immediately
    - Push lawmakers to cosponsor H.R. 6683 and H.R. 2474
    - Action kit from the National Advocacy Conference (NAC)
    - Need to make sure we're included in March and remove the totality of the cut

- AMA Policy Research Perspective, Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022



Source: Author's analysis of AMA 2022 Physician Practice Benchmark Survey.
Note: These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were practice members at the time of that acquisition (N=282). The bracketed percentage is the sum of important (4) and very important (5).

- **2024 Medicare Physician Payment Schedule Final Rule**

- 2024 MPS Final Rule – Impact of the RUC
  - CMS accepted and is implementing 97 percent of RUC recommendations for new/revised Current Procedural Terminology® (CPT®) codes and codes identified via the RUC's potentially misvalued services process.
  - In the RUC's efforts to ensure gender equity in valuation, the RUC identified that the additional resources required to provide a pelvic exam during an E/M service should be recognized and, therefore, referred the issue to the CPT Editorial Panel. The Panel created a new CPT code, and the RUC reviewed the new service and submitted its recommendation to CMS. CMS accepted the recommendation as proposed — the new pelvic exam CPT code will be implemented on January 1, 2024.
  - CMS accepted the RUC recommendation to increase maternity services to incorporate increases to the hospital E/M services, consistent with the RUC recommendations to incorporate the E/M increases into post-operative office and hospital visits in codes with global periods.

- 2024 MFS Final Rule – Positive Outcomes
  - CMS lowered its estimate of utilization of the new add-on code for "inherent complexity" from 90% in 2021 to 38% in 2024, which reduced the budget neutrality adjustment for the code.
  - CMS adopted the CPT guidelines definition of a "substantive portion" of a split (or shared) visit, which will allow the physician or QHP to bill based on time or medical decision-making.
  - CMS maintained the existing weights for the Medicare Economic Index (MEI) until data is available from the AMA's survey of physicians' expenses.

  - Congress and CMS extended through end of 2024 all Medicare telehealth policies, including
    - Telehealth available all over the country,
    - Ability to provide to patients in their homes,
    - Ability to be paid for telephone visits,
    - Provide direct supervision virtually, provide supervision of residents virtually,
    - No limit on provision of subsequent nursing facility or inpatient hospital services via telehealth,
    - Continuation of the Acute Hospital at Home program, and
    - Continue to receive nonfacility (office) payment rates for telehealth services delivered to patients in their homes.
  - CMS did not impose a requirement for physicians providing telehealth from their homes to report their home address on their Medicare enrollment information.
  - Medicare will now start covering the HbA1c test to screen for diabetes and prediabetes, and will continue to allow Medicare Diabetes Prevention Program services to be delivered virtually.
  - CMS finalized its proposal to pause implementation of the Appropriate Use Criteria (AUC) program and rescind the current program regulations due to issues with the claims-based reporting requirements for ordering and furnishing physicians.
  - In response to opposition from the AMA and physician groups, CMS did not finalize its proposal to include misdemeanor convictions as a reason to revoke a Medicare provider's or supplier's enrollment.

- **2024 Medicare Quality Payment Program (QPP)**

- 2024 Merit-based Incentive Payment System (MIPS)
  - In response to advocacy from organized medicine, CMS maintained the MIPS performance threshold to avoid a penalty at 75 points in 2024.
    - As a result, CMS estimates that 78% of eligible clinicians will avoid a penalty and/or earn a bonus.
  - CMS added five optional MIPS Value Pathways (MVPs):
    - Focusing on Women's Health
    - Quality Care for the Treatment of Ear, Nose, and Throat Disorders
    - Prevention and Treatment of Infectious Disorders including Hepatitis C and HIV
    - Quality Care in Mental Health and Substance Use Disorders
    - Rehabilitative Support for Musculoskeletal Care
  - CMS increased the performance period for Promoting Interoperability measures from 90 days to 180 days.

- MIPS Under Scrutiny
  - In August, when CMS released MIPS Feedback Reports, the AMA began to hear from physicians who were previously successful in MIPS that they were going to be subject to a penalty in 2024 based on the 2022 performance period.
    - CMS increased the performance threshold
    - Automatic COVID-19 hardship exceptions expired
    - Cost measures counted as 30% of final scores unless in an APM
  - Sept. 18 letter reiterates the lack of timely and useful data feedback in the MIPS program for physicians.

  - Sept. 28 letter highlighted our concern that physicians will be unfairly penalized in the MIPS program in 2024, which would be in addition to the -3.37% reduction to the conversion factor next year.
  - Oct. 18 AMA Statement for House Energy and Commerce Subcommittee on Health hearing, "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors" highlighted statutory barriers to improving MIPS.
  - Oct. 27 letter outlines problems with the 2022 cost measures that are leading to 2024 MIPS penalties, including total per capita cost and episode-based cost measures.
  - Dec. 18 letter describes additional problems with the 2022 cost measures and urges CMS to exclude them from MIPS final scores.

- Alternative Payment Models (APMs)
  - CMS finalized its proposal to delay mandatory eCQM adoption by Medicare Shared Savings Program (MSSP) participants in 2024. Participants may continue to use the CMS Web Interface for reporting quality measures.
  - AMA is part of several coalitions supporting the Value in Healthcare Act, which would extend the incentive payment for qualifying APM participants (QPs)
    - 3.5% incentive expired at the end of 2023.
    - Under current law, QPs will receive a 0.75% update in 2026 based on 2024 performance, while non-QPs will receive a 0.25% update.

- **Prior Authorization (PA)**

- CMS Interoperability and Prior Authorization Final Rule
  - Hot off the press – CMS issued the rule on Jan. 17.
  - Important reforms will reduce burden, cut delays for patients and save physicians $15 billion over 10 years according to HHS' estimate.
  - Starting in 2026, affected payers will have to send prior authorization decisions within 72 hours for urgent requests and within a week for nonurgent requests. For some payers, CMS noted that would represent a 50% improvement.
    - The AMA strongly advocated faster time frames, and CMS said it will consider updating its policies in future rulemaking.
  - Beginning in 2026, impacted payers must provide a specific reason for denied PA decisions
  - Beginning in 2026, CMS is requiring impacted payers to publicly report certain PA metrics, including approval and denial rates and average processing time, annually on their websites
  - Note the rule applies to medical services in government-regulated health plans, including:
    - Medicare Advantage
    - State Medicaid and Children's Health Insurance Program (CHIP) fee-for-service programs
    - Medicaid managed care plans and CHIP managed care entities
    - Qualified health plan issuers on the federally facilitated exchanges

- Ms. Hananoki addressed questions from the attendees:
  - A RUC member inquired about the AMA's initiatives or discussions related to private equity investors and the impact on the health care industry. Ms. Hananoki responded that there were recent discussions at the House of Delegates (HOD) meeting related to the impact of private equity on physicians, hospitals and the impact on quality of care.

- The RUC member posed a different question related to increased E/M valuation and if the AMA is considering why those RVU and payment increases are not normally passed on to doctors who work in hospital systems. Ms. Hananoki responded that the AMA is aware of this issue and that conversations are occurring. She offered an example of when COVID-19 relief funds were not making their way to frontline physicians and the AMA created a sample letter that physicians could send to their facility stating the intent of Congress. To date, a similar letter has not been drafted but it is an effective option that the AMA is considering to address the issue.

IX. Relative Value Recommendations for CPT 2025

Skin Cell Suspension Autograft (Tab 4)
Jeffrey Carter, MD (ABA), James Holmes, MD (ABA), Taryn Travis, MD (ABA)
Facilitation Committee #1

In September 2023, the CPT Editorial Panel approved the creation of eight new CPT codes to describe skin cell suspension autograft (SCSA) procedures. The CPT Editorial Panel also revised the introductory guidelines for Skin Replacement Surgery to account for these new services.

The code set includes a 000-day global (15011) and an add-on code (15012) describing the harvesting component of the procedure, an XXX global (15013) and an add-on code (15014) describing the preparation component of the procedure, and two 090-day global and add-on codes for the application component to distinguish between body areas (trunk, arms, and legs-15015 and 15017; face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, or multiple digits-15016 and 15018).

SCSA procedures enable surgeons to treat a much larger area of burn wound with a significantly smaller amount of harvested skin and involve performing complex calculations to determine the harvest size needed. The surgeon harvests the appropriately sized epidermal layer and a very thin dermal layer of skin. The harvested graft is then processed into a suspension using enzymatic digestion and manual disaggregation of the cells. Following processing, the expansion ratio of the SCSA graft which describes the area harvested and treated can be up to 1:80 harvest to expansion, unlike existing epidermal autograft and split-thickness skin graft procedures where the expansion ratio of the graft is typically 1:2. Per the CPT Introductory Guidelines, "The expansion ratio of harvested skin to prepare a skin cell suspension autograft is typically 1:80 and, for example, 25 sq cm of harvested skin will produce a quantity of skin cells sufficient to cover a defect measuring up to 2000 sq cm." Next, a primary dressing is partially affixed to the wound bed. The SCSA graft is then applied to the prepared burn wound, and the primary dressing is fully affixed to the wound. Secondary and tertiary dressings are then applied. The autograft requires diligent post-operative care due to its fragile, thin nature while it undergoes maturation.

The RUC evaluated the new SCSA codes and recommended applying the median intra-service survey times and physician work values across the family of codes, as supported by the survey; removing duplicative pre-service time; and supporting the number and intensity of inpatient and outpatient post-operative visits.

15011 ***Harvest of skin for skin cell suspension autograft; first 25 sq cm or less***
The RUC reviewed the survey results from 33 burn surgeons and determined that the survey median work RVU of 3.00 appropriately accounts for the work typically required to perform this service. The RUC recommends 55 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 40 minutes intra-service time, and 20 minutes immediate post-service time, totaling 140 minutes of total time. The pre-service time includes time

that was moved from CPT codes 15015 and 15017 to address any duplication. This move is appropriate as the harvest base code will always be paired with one of the two base application codes, and therefore CPT code 15011 now includes all the pre-service time for this episode of care and 15015 and 15017 have no pre-service time. The RUC agreed this change supports the flow of work and noted that it includes distinct pre-operative education for patients specific to the graft preparation and application components of the procedure.

To support the median value for CPT code 15011, the RUC compared the surveyed code to the top key reference service 15040 *Harvest of skin for tissue cultured skin autograft, 100 sq cm or less* (work RVU = 2.00, 15 minutes intra-service time and 60 minutes total time) and noted that the reference service involves much less intra-service and total time and is therefore appropriately valued lower than the surveyed code. The new CPT codes 15011-15012 for the harvest procedures are necessary as the reference code does not accurately describe the harvest procedure performed for SCSA, as this new technology requires more physician time and is more intense than 15040.

For additional support, the RUC compared the surveyed code to MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.55, 40 minutes intra-service time and 78 minutes total time) and noted that the comparator code requires more physician work in less total time than the surveyed code and therefore is appropriately valued higher. The RUC also referenced CPT code 32408 *Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed* (work RVU = 3.18, 40 minutes intra-service time and 101 minutes total time) and noted the identical intra-service time and similar amount of physician work as the surveyed code. **The RUC recommends a work RVU of 3.00 for CPT code 15011.**

15012 ***Harvest of skin for skin cell suspension autograft; each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 33 burn surgeons and determined that the survey median work RVU of 2.00 appropriately accounts for the work involved in this add-on service to capture additional harvesting beyond the initial 25 sq cm. The RUC recommends 40 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15012, the RUC compared the surveyed code to the top key reference service 15101 *Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.72, 29 minutes intra-service time and total time) and noted that the reference service involves much less intra-service time and is therefore appropriately valued lower than the surveyed code. For 15012, depending on the patient's condition, the size of the burn wound and the harvest needed, the surgeon will harvest the first 25 sq cm (15011). Next, the surgeon will harvest the remaining 25 sq cm and prepare that harvest (15013). This technique is typical, in that, it is how a surgeon will conserve donor skin and only harvest what is truly needed. Additionally, in the typical patient, the work can become more complex due to several factors such as device failure, contamination, mis-spray where cells are disposed of accidentally, or miscalculation which all can require re-harvest.

For additional support, the RUC compared the surveyed code to CPT code 20937 *Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)* (work RVU = 2.79, 40 minutes intra-service time and total time) and CPT code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 2.19, 35 minutes intra-service time and total time) which

require similar physician work and time. **The RUC recommends a work RVU of 2.00 for CPT code 15012.**

15013 ***Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin***
The RUC reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 2.51 appropriately accounts for the work typically required to perform this service. The RUC recommends 33 minutes intra-service and total time. The Committee removed the pre-service evaluation time from code 15013 since all pre-service time is already accounted for in the harvest code 15011, which is always reported together for this episode of care.

To support the median value for CPT code 15013, the RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60, 60 minutes total time) and noted that the reference code requires more time and is therefore valued slightly higher than the surveyed code. The RUC further noted that the surveyed code is appropriately bracketed by the two key reference service MPC codes, 99204 and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.92, 47 minutes total time), although the survey respondents indicated that 15013 is more complex than both 99204 and 99214.

For additional support, the RUC compared the surveyed code to MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time) and CPT codes 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time) and 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time) all of which have slightly lower intra-service times, therefore justifying a slightly higher value for the surveyed code. **The RUC recommends a work RVU of 2.51 for CPT code 15013.**

15014 ***Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 2.00 appropriately accounts for the work involved in this add-on service to capture additional preparation beyond the initial 25 sq cm. The RUC recommends 28 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15014, the RUC compared the surveyed code to both of the key reference services 15152 *Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.50, 20 minutes intra-service time and total time) and 15156 *Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)* (work RVU = 2.75, 20 minutes intra-service time and total

time) and noted that the reference services are complex grafting procedures rather than preparation of the harvested skin, thus the reference services are more intense and appropriately valued higher than the surveyed code.

For additional support, the RUC compared the surveyed code to CPT code 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (work RVU = 2.23, 30 minutes intra-service time and total time) and CPT code 49435 *Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (List separately in addition to code for primary procedure)* (work RVU = 2.25, 30 minutes intra-service time and total time) which require slightly higher intra-service times that correspond with slightly higher work values. **The RUC recommends a work RVU of 2.00 for CPT code 15014.**

15015 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; first 480 sq cm or less***
The RUC reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 10.97 appropriately accounts for the work typically required to perform this service. The RUC recommends 0 minutes pre-service time, 83 minutes intra-service time, 30 minutes immediate post-service time, 4-99232 subsequent hospital inpatient visits, 1-99238 discharge visit, and 4-99213 post-operative office visits, totaling 403 minutes of total time. The RUC reallocated all pre-service time from the surveyed code to 15011 as the harvest base code will always be paired with one of the two base application codes during an episode of care.

In addition to monitoring the patient's stability in the recovery room, writing orders, communicating with the family and other health care professionals (including written and oral reports and orders) as in 15011, the 30 minutes of immediate post-operative work includes additional time to account for all hospital visits and services performed by the surgeon in the intensive care unit or on a suitable nursing floor.

Following SCSA procedures, several post-op office visits are required for burn wound patients which include the following:

- Monitoring healing
- Multiple dressing changes
- Managing pain
- Return to work and activity counseling
- Assessing for possible infection
- Concomitant medication management
- Assessing compliance with therapy (PT/OT)
- Monitoring nutritional status and dietary intake

Additionally, all post-discharge office visits for this procedure, including removing sutures, changing dressings, and providing antibiotic and pain medication adjustments, for 90 days after the day of the operation are considered part of the postoperative work for this procedure. Of note, SCSA procedures require more frequent post-operative secondary dressing changes. Following SCSA procedures, secondary dressings are changed 3 times per week (compared to epidermal autograft procedures which are changed 1 time per week) to monitor wound healing status and prevent/treat any infections. The RUC expressed concern regarding the negative IWPUT for code 15015 (-0.005) and considered adjusting the post-operative visits to resolve this issue. However, the Committee was convinced by the cogent arguments from the specialty that the number and intensity of post-operative visits should be maintained for this critically ill patient population. Both the inpatient and outpatient visits were determined to be appropriate.

To support the median value for CPT code 15015, the RUC compared the surveyed code to the top key reference service 15110 *Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children* (work RVU = 10.97, 28 minutes intra-service time and 306 minutes total time) and noted that the intra-service times are vastly different and that graft application codes typically use 100 square centimeters for their size which is different than the surveyed code treatment of up to the first 480 square centimeters.

For additional support, the RUC compared the surveyed code to CPT code 34490 *Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision* (work RVU = 10.91, 80 minutes intra-service time and 367 minutes total time) and CPT code 32097 *Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 13.75, 80 minutes intra-service time and 401 minutes total time) which require similar physician work and time. **The RUC recommends a work RVU of 10.97 for CPT code 15015.**

15016 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 2.50 appropriately accounts for the work involved in this add-on service to capture the additional graft application component of the procedure for the trunk, arms and legs area of the body. The RUC recommends 25 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15016, the RUC compared the surveyed code to the top key reference service 15116 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.50, 35 minutes intra-service time and total time) and noted there is a similar amount of physician work for the additional grafting procedure despite the differences in size.

For additional support, the RUC compared the surveyed code to CPT code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU = 2.50, 25 minutes intra-service time and 32 minutes total time) noting a strong comparison as the services have the same amount of physician work and intra-service time. The RUC further referenced CPT codes 32506 *Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* (work RVU = 3.00, 25 minutes intra-service time and total time) and 36907 *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)* (work RVU = 3.00, 25 minutes intra-service time and total time) which also require the same intra-service time as the surveyed code. **The RUC recommends a work RVU of 2.50 for CPT code 15016.**

15017 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less***
The RUC reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 12.50 appropriately accounts for the work required to perform this service. The RUC recommends 0 minutes pre-service time, 75 minutes intra-service time, 30 minutes immediate post-service time, 4-99232 subsequent hospital inpatient visits, 1-99238 discharge visit, and 4-99213 post-operative office visits, totaling 395 minutes of total time. The RUC reallocated all pre-service time

from the surveyed code to 15011 as the harvest base code will always be paired with one of the two base application codes during an episode of care.

In addition to monitoring the patient's stability in the recovery room, writing orders, communicating with the family and other health care professionals (including written and oral reports and orders) as in 15011, the 30 minutes of immediate post-operative work includes additional time to account for all hospital visits and services performed by the surgeon in the intensive care unit or on a suitable nursing floor.

Following SCSA procedures, several post-op office visits are required for burn wound patients which include the following:

- Monitoring healing
- Multiple dressing changes
- Managing pain
- Return to work and activity counseling
- Assessing for possible infection
- Concomitant medication management
- Assessing compliance with therapy (PT/OT)
- Monitoring nutritional status and dietary intake

Additionally, all post-discharge office visits for this procedure, including removing sutures, changing dressings, and providing antibiotic and pain medication adjustments, for 90 days after the day of the operation are considered part of the postoperative work for this procedure. Of note, SCSA procedures require more frequent post-operative secondary dressing changes. Following SCSA procedures, secondary dressings are changed 3 times per week (compared to epidermal autograft procedures which are changed 1 time per week) to monitor wound healing status and prevent/treat any infections.

To support the median value for CPT code 15017, the RUC compared the surveyed code to the top key reference service 15115 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children* (work RVU = 11.28, 35 minutes intra-service time and 356 minutes total time) and noted that the intra-service times are vastly different and that graft application codes typically use 100 square centimeters for their size which is different than the surveyed code treatment of up to the first 480 square centimeters.

For additional support, the RUC compared the surveyed code to CPT code 27540 *Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed* (work RVU = 11.30, 75 minutes intra-service time and 334 minutes total time) and CPT code 50205 *Renal biopsy; by surgical exposure of kidney* (work RVU = 12.29, 75 minutes intra-service time and 324 minutes total time) which require identical intra-service time and similar physician work and total time. **The RUC Committee recommends a work RVU of 12.50 for CPT code 15017.**

15018 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 3.00 appropriately accounts for the work involved in this add-on service to capture the

additional graft application component of the procedure for the body areas other than the trunk, arms, and legs. The RUC recommends 30 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15018, the RUC compared the surveyed code to the top key reference service 15116 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.50, 35 minutes intra-service time and total time) and noted there are stronger comparisons to several ZZZ codes with identical intra-service time and physician work: 64913 *Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)* (work RVU = 3.00, 30 minutes intra-service time and total time) and 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, 30 minutes intra-service time and total time) and 47543 *Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)* (work RVU = 3.00, 30 minutes intra-service time and total time). **The RUC recommends a work RVU of 3.00 for CPT code 15018.**

Practice Expense
The RUC considered the recommendations of the Practice Expense (PE) Subcommittee. However, the specialty modified its recommendation to only recommend direct practice inputs for the facility setting and withdrew its non-facility recommendations since the procedure will only be performed in the facility setting at present. Only CPT codes 15015 and 15017 include facility inputs. For these two codes, the 090-day global standards for the use of clinical staff in the facility are recommended for the pre-service times. Several supplies are recommended for 15015 and 15017 including one SA031 *kit, suture removal* as sutures are removed at the first post-operative office visit after discharge. Also, SG020 *bandage, Kling, sterile 4in* was added for these two codes that include follow up visits at 40 units each. This is the total amount of sterile Kling bandage used for the first two post-operative visits, or 20 units per visit, for the first two visits. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee for the facility setting only.**

Do Not Use to Validate for Physician Work
The RUC recommends that CPT codes 15011-15018 be flagged in the RUC database to not be used to validate physician work.

New Technology
The RUC recommends that CPT codes 15011-15018 be placed on the New Technology list to be re-reviewed by the RUC and notes that the codes should be reviewed for both work and PE after one year of claims data. The 2025 Medicare claims data will be available for review at either the September 2026 or January 2027 RUC meeting. At that time, the RUC would consider if other specialties are performing the service and if the service is performed in the non-facility setting.

Bladder Neck and Prostate Procedures (Tab 5)
Jyoti Chouhan, DO (AUA), Seth Cohen, MD (AUA), Jonathan Kiechle, MD (AUA), Thomas Turk, MD (AUA)

In September 2023, the CPT Editorial Panel created two Category I CPT codes to describe the insertion or removal of a temporary device to remodel the bladder neck and prostate using pressure to

create necrosis and relieve lower urinary tract symptoms (LUTS) secondary to benign prostate hyperplasia (BPH).

53865 ***Cystourethroscopy with insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate***
The RUC reviewed the survey results from 60 urologists and determined that a work RVU of 3.10 appropriately accounts for the work required to perform this service. The RUC recommends 28 minutes pre-service evaluation time, 5 minutes positioning time, 8 minutes scrub/dress/wait time, 20 minutes intra-service time and 14 minutes post-service time. During the pre-service period, pre-operative imaging results are reviewed to evaluate the prostate volume and anatomy, blood and urine testing results are reviewed, and the procedure is discussed with the patient and anesthesiologist. During the intra-service period, the remodeling device must be placed precisely in the prostate to avoid the sphincter complex and ensure it will not migrate during the 5–7-day period in which it is left in place.

While the procedure is difficult and intense throughout the 20 minutes of intra-service time, the specialty society indicated that the survey 25th percentile work RVU of 3.91 was too high for this procedure compared to other services in the Medicare Physician Payment Schedule with similar intra-service time. Therefore, the specialty society recommended and the RUC agreed, that the recommended work RVU for CPT code 53865 should be crosswalked to CPT code 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* (work RVU = 3.10, 20 minutes intra-service time and 71 minutes total time). These procedures are similar in intensity and both require precise placement of an intraurethral device.

The RUC compared the surveyed code to the second top key reference service, 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, 20 minutes intra-service time and 46 minutes total time) and noted that 71% of survey respondents indicated that overall, the surveyed code is somewhat more intense than code 52281 and 57% stated that that it would require more technical skill. The surveyed code requires more physician work and time to perform and is more intense and complex, thus appropriately valued higher than CPT code 52281.

For additional support, the RUC referenced MPC code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU = 4.00, 25 minutes intra-service time and 81 minutes total time), which requires more intra-service time and total time, thus places CPT code 53865 appropriately lower. **The RUC recommends a work RVU of 3.10 for CPT code 53865.**

53866 ***Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate***
The RUC reviewed the survey results from 60 urologists and determined that a work RVU of 1.48 appropriately accounted 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, 10 minutes intra-service time and 10 minutes post-service time. While the procedure is intense throughout the entirety of the intra-service period, the specialty society indicated that the survey 25th percentile work RVU of 2.00 was too high for this procedure compared to other services in the Medicare Physician Payment Schedule with similar intra-service time. Therefore, the specialty society recommended and the RUC agreed, that CPT code 53866 should have a direct work RVU crosswalk to CPT code 27096 *Injection procedure for sacroiliac joint, anesthetic/steroid, with image*

guidance (fluoroscopy or CT) including arthrography when performed (work RVU = 1.48, 11 minutes intra-service time and 38 minutes total time).

The RUC discussed how much time is required for the pre-service evaluation for code 53866, as it closely follows the performance of 53865. During the pre-service period for 53866, the physician reevaluates the urine culture results and typically orders a different antibiotic, considering that this procedure occurs in a non-facility setting, likely without intravenous access. Once again, the physician engages in a discussion with the patient about the procedure discussing possible hematuria, dysuria and symptoms since device placement, obtains consent for device removal without cystoscopic guidance, and ensures that the necessary equipment is available and properly set up.

Within the intra-service period, 53866 involves grasping the previously placed device and suture. These are then brought through a catheter that has been modified to facilitate device removal. The catheter is advanced into the device, and careful manipulation is required to pull the entire device back into the catheter. This maneuver demands significant care to ensure the safe and complete entry of the device into the catheter. Failing to do so may pose a risk of damaging the external urethral sphincter complex and the anterior urethra, particularly as the device is pulled out through the external sphincter in the urethra.

For additional support the RUC referenced codes 52000 *Cystourethroscopy (separate procedure)* (work RVU = 1.53, 10 minutes intra-service time and 40 minutes total time), 45305 *Proctosigmoidoscopy, rigid; with biopsy, single or multiple* (work RVU = 1.15, 10 minutes intra-service time and 40 minutes total time), and 64430 *Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)* (work RVU = 1.10, 10 minutes intra-service time and 40 minutes total time), which all require similar intra-service time, total time and bracket the valuation for 53866. **The RUC recommends a work RVU of 1.48 for CPT code 53866.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for CPT codes 53865 and 53866. The RUC noted that the removal (53866) of the temporary device typically occurs 5-7 days after the insertion (53865), therefore the phone call in the pre-service period of 53866 was removed to eliminate any overlap with the post-service phone call in 53865. In addition, several supplies were removed to eliminate duplication with the packs and equipment minutes were adjusted since the specialty society indicated that a rigid cystoscope is used in code 53865, not a flexible cystoscope. The PE Subcommittee acknowledged the new high-cost supply input, iTIND device, as recommended for CPT code 53865. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 53865 and 53866 will be placed on the New Technology list to be reviewed in three years to ensure correct valuation, patient population, and utilization assumptions.

<u>Guided High Intensity Focused Ultrasound (Tab 6)</u>
Joshua Rosenow, MD (AANS)

In September 2023, the CPT Editorial Panel created a new Category I code to describe magnetic resonance image guided high intensity focused ultrasound intracranial ablation for treatment of a severe central tremor that is recalcitrant to other medical treatments. This service is typically

performed by a neurosurgeon without the involvement of a separate radiologist. This new code replaces the existing Category III code, 0398T.

61715 ***Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed***

The RUC reviewed the survey results from 31 neurosurgeons who specialize in functional neurosurgery and recommends a work RVU of 18.95 based on the survey 25th percentile. The RUC recommends 65 minutes of pre-service evaluation time, 30 minutes positioning time, 15 minutes scrub/dress/wait time, 150 minutes intra-service time, and 40 minutes immediate post-service time, and 300 minutes total time. The pre-service evaluation time for this procedure includes additional coordination with multiple healthcare providers for preoperative planning and approach related to the extensive pre-procedure CT and MR scans. The patient history, laboratory results, and procedure plan are reviewed in detail and communicated with the patient. Further, preoperative MRI volumetric planning is performed just prior to the procedure as well as preparing the MRI and accompanying software. The positioning time requires rigid skull fixation to the MRI equipment ensuring no gaps or bubbling between the skin and the rubber membrane of the fixture. Once secured, seamless circulation of the cool water surrounding the skull is assessed. The scrub/dress/wait time is attributed to the work of administering the local anesthesia, observing anesthesia care, in addition to dressing and scrubbing for the procedure. Further, the RUC determined that the total post service time of 40 minutes was appropriate as it includes additional work related to disconnecting the patient from the treatment equipment and removal of hardware. In addition, documentation that includes intraoperative imaging and treatment will require additional time that is not included in the 8b post-time package. Postoperative work on the day of the procedure will also include the evaluation and management services performed after discharge from recovery to observation for critical monitoring of the patient's neurological status later the same day. Separate Evaluation and Management (E/M) services are not typically reported with this service.

For this procedure, the patient is in the MRI suite and the pre-service and intra-service MR and CT images are used to determine the target focal point and determine baseline tremor symptoms. Low intensity sonication is initiated to align the transducer to the anatomic target, raising the tissue temperature, and assessed with real-time MR imaging. This process is repeated until the heat spot coincides with the anatomic target. The tissue temperature is increased, and the physician evaluates the tremor and adjusts the treatment accordingly based on the physiological response. Once the treatment location is precisely identified, sonication is applied to raise the temperature once again while continuous patient monitoring occurs until the desired treatment and resolution of the tremor is achieved.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 61736 *Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion* (work RVU = 19.06, 180 minutes intra-service, and 353 minutes total time) and 61737 *Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)* (work RVU = 22.67, 235 minutes intra-service, and 474 minutes total time). The KRS codes require similar intensive pre-service work, however, a portion of the intra-service work of the KRS codes can be attributed to surgical exposure and closure as well as intraoperative patient transport, both of which are less intense activities than the intra-service work of the surveyed code. Specifically, the surveyed code should be valued similarly to KRS code 61736 given the greater complexity and medical decision making involved despite lower intra-service and total time. Survey respondents,

who had experience with the key reference codes, indicated that the surveyed code was identical or somewhat more intense than code 61736 further supporting the recommended work RVU.

For additional support, the RUC compared the surveyed code to CPT code 33894 *Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches* (work RVU = 18.27, 134 minutes intra-service, and 284 minutes total time). The surveyed code is valued appropriately higher than the comparison code given the longer intra-service and total time despite slightly lower overall intensity and complexity. **The RUC recommends a work RVU of 18.95 for CPT code 61715.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the facility-only service and agreed with the standard inputs for extensive use of clinical staff time during the pre-service period. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology
CPT code 61715 will be placed on the New Technology list to be reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

Percutaneous Radiofrequency Ablation of Thyroid (Tab 7)
Curtis Anderson, MD (OEIS), Salomao Faintuch, MD (SIR), Chase Hendrickson, MD (ES), Minhajuddin Khaja, MD (SIR), Peter Manes, MD (AAO-HNS), Lauren Nicola, MD (ACR)

At the September 2023 CPT Editorial Panel meeting, CPT codes 60660 and 60661 were created to report percutaneous radiofrequency ablation of one or more thyroid nodule(s). This service is typically performed on patients presenting with dysphagia with certain thyroid conditions, most commonly benign nodules located in one lobe or the isthmus. Employing a minimally invasive surgical technique, a physician will target and remove abnormal or overactive thyroid tissue as a form of treatment for symptom relief. CPT code 60660 represents the ablation of a thyroid nodule(s) in one lobe of the thyroid or the isthmus, and CPT code 60661 is its corresponding add-on code for each additional thyroid nodule in the contralateral lobe. Both codes in this family were surveyed for the January 2024 RUC meeting.

60660 ***Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency***
The RUC reviewed the results from 156 respondents from a multi-disciplinary survey and determined that a work RVU of 5.75 appropriately accounted for the physician work required to perform this service. The RUC recommends 33 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 40 minutes intra-service time and 20 minutes immediate post-service time, equaling 113 minutes total time. Based on the discussion at pre-facilitation, the RUC indicated that the survey 25th percentile work RVU of 6.00 was too high for the physician work involved with this procedure. Therefore, the specialty societies recommended that CPT code 60660 be valued based on a direct work RVU crosswalk to CPT code 52351 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic* (work RVU = 5.75, 45 minutes intra-service time and 118 minutes total time). These procedures have similar intensity, similar intra-service time, and comparable physician work.

During the pre-service time period, results of pre-operative imaging are reviewed to evaluate the chosen nodule(s) for treatment, the patient is positioned supine on the procedure table, and ultrasound guidance is performed to ensure the patient's neck has been properly extended and rotated at an oblique angle to identify the target nodule(s) and establish an appropriate window for treatment.

During the intra-service time period, an ablation probe is advanced into the target lesion(s) under ultrasound guidance using an in-plane oblique angle. The probe is intermittently repositioned while treating the lesion(s) using a thyroid-specific ablation technique.

The specialty society selected pre-service time package *3-FAC Straightforward Patient/Difficult Procedure* and post-service time package *8B IV Sedation/Complex Procedure.* Both standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. Seven minutes of pre-service positioning time were added to the pre-service time package in accordance with the median survey time of ten minutes. Additional time is necessary to safely position the patient, extended and rotated in a manner such that the lesion is appropriately positioned within the treatment window. The extra time also accounts for the re-positioning of the patient and their neck during the procedure requiring additional ultrasound scanning. Five minutes of pre-service scrub/dress/wait time were removed from the pre-service time package in accordance with the median survey time of ten minutes. Eight minutes were removed from the immediate post-service time package in accordance with the median survey time of twenty minutes. The RUC agreed with all modifications to both the pre-service and post-service time packages.

To support the recommended work RVU value of 5.75, the RUC compared the surveyed code to the top key reference service and MPC code 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU = 5.30, 45 minutes intra-service time and 94 minutes total time). The RUC noted that CPT code 60660 requires more total time overall and is more intense and complex to perform than CPT code 36475, thus appropriately valued higher. Though both services involve radiofrequency ablation, the RUC noted that the surveyed code employs a complex in-plane oblique approach to identify and treat the target nodule(s) and recognized that intermittent probe repositioning is necessary when conducting repetitive small-volume overlapping ablations involved with this more intense thyroid-specific ablation technique. For additional support, the RUC referenced CPT codes, 31255 *Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)* (work RVU = 5.75, 45 minutes intra-service time and 98 minutes total time) and 28003 *Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas* (work RVU = 5.28, 45 minutes intra-service time and 130 minutes total time). Both referenced services have similar total time and similar intra-service time as the surveyed code and therefore the surveyed code should be valued similarly. **The RUC recommends a work RVU of 5.75 for CPT code 60660.**

60661 ***Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service)***
The RUC reviewed the results from 145 respondents from the multi-disciplinary survey and determined that a work RVU of 4.25 appropriately accounted for the physician work required to perform this service. CPT code 60661 is an add-on code describing the radiofrequency of each additional thyroid nodule in the contralateral lobe or isthmus. The RUC recommends 45 minutes of intra-service time, which also represents the total time. Based on the discussion at pre-facilitation, the RUC indicated that the survey 25th percentile work RVU of 4.92 was too high for the physician work involved with this procedure. Therefore, the specialty societies recommended that CPT code 60661 should be valued based on a direct work RVU crosswalk to CPT code 37223 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU = 4.25, 45 minutes of intra-service and 47 minutes total time). These procedures have similar intensity, identical intra-service time, and comparable physician work.

During the intra-service time period, an ultrasound evaluation of the contralateral lobe is performed to locate the new benign target lesion(s). There is typically increased difficulty in locating a second lesion due to an obstructed view resulting from overlying gas bubbles from the prior ablation. CPT code 60660, an ablation probe is advanced into the target lesion(s) under ultrasound guidance using an in-plane oblique angle. The probe is intermittently repositioned while treating the lesion(s) using the same thyroid-specific ablation technique as CPT code 60660.

To support the recommended work RVU value of 4.25, the RUC compared the surveyed code to the top key reference service 37186 *Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)* (work RVU = 4.92, 60 minutes intra-service and total time). The RUC agreed with survey respondents and recognized that while CPT code 60661 involves greater complexity and intensity than CPT code 37186, the surveyed code requires less total time and physician work to perform overall than the top key reference service, and thus is appropriately valued lower to maintain relativity. **The RUC recommends a work RVU of 4.25 for CPT code 60661.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed CPT codes 60660 and 60661 and made modifications to several supply inputs to appropriately account for the physician and three clinical staff performing the procedure during the intra-service of the service period (L041A *Vascular Interventional Technologist*, L042B *RN/LPN*, and L050B *Diagnostic Medical Sonographer)*. The PE Subcommittee acknowledged the new equipment input, *RF Ablation System V1000 and RF Pump*, for the two codes and the new high-cost supply input, *RF Electrodes, 18 Gauge, 70mm Length,* as recommended for code 60660. The specialty societies clarified that this is a one-time use supply item utilized to ablate the node(s) in the thyroid. The RUC continues to call on CMS to separately identify and pay for high cost disposable supplies using appropriate HCPCS codes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 60660 and 60661 will be placed on the New Technology list to be reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

Fascial Plane Blocks (Tab 8)
Trent Emerick, MD (ASRA-PM), Gordon Morewood, MD (ASA), Richard Rosenquist, MD (ASA), Matthew Thames, MD (ASRA-PM)

In September 2023, the CPT Editorial Panel created six new Category I CPT codes to report thoracic or lower extremity fascial plane blocks, typically used for post-operative pain management. Four existing CPT codes describing transversus abdominis plane (TAP) blocks were included as part of this code family for RUC review in January 2024. The physician work for this family of services varies based on the anatomic region of the fascial plane block, whether the service is unilateral or bilateral and whether the service involves continuous infusion by catheter. Image guidance, when performed, is also included in each of the 10 procedures for this code family, and therefore, cannot be separately reported.

Regional Anesthesia and Acute Pain Teams

The specialties noted that in current clinical practice and based on the experience of their expert panel, fascial plane blocks are typically provided by a separate acute pain management physician who works within a dedicated acute pain team that is separate from the operating room anesthesiologist and anesthetic team. It is typical for a separate acute pain management physician to place the fascial plane block. Most anesthesiologists in the United States are not currently experienced in performing fascial plane blocks. Placing a fascial plane block requires specialized training and experience to recognize the ultrasound anatomy and achieve reliable results. Therefore, it is typical for an acute pain management fellowship trained physician, who works within a dedicated acute pain team that is separate from the operating room anesthesiologist and anesthetic team that is providing their care during surgery, to perform fascial plane blocks.

Regional anesthesia has undergone and continues to undergo changes related to techniques and targets for plane blocks. This is attributable to the use of ultrasound guidance that has allowed visualization of nerve bundles and in more recent years the development and performance of fascial plane blocks. Fascial plane blocks were not a part of the training for the majority of practicing anesthesiologists. In recognizing the changing nature of regional anesthesia and the growth of acute pain services requiring more specialized skills, training and experiences, residency programs created one-year subspecialty regional anesthesiology clinical fellowships. In 2016, individual training programs in regional anesthesiology and acute pain medicine became eligible for accreditation by the Accreditation Council for Graduate Medical Education. This has created more uniform program requirements and educational experiences. The graduates of these programs are contributing to more widespread adoption of dedicated regional anesthesia and acute pain medicine programs and acute pain. Teams perform blocks and improve care in a variety of settings, including academic centers and community hospitals. Based on the information provided by the specialties about acute pain teams and changes in regional anesthesia, the RUC concurred that the pre-service and post-service time proposed by the specialties was warranted for each of the 10 codes.

Fascial Plane Blocks by Anatomic Region

Fascial plane block procedures are more intense than many other types of blocking procedures (ie a femoral nerve blocks), because during a fascial plane block procedure, the acute pain management physician must first identify the fascial plane, then separate the bordering muscles by hydro-dissection before passing the needle or catheter. The intensity and complexity of fascial plane block procedures vary by anatomic region. The specialties and RUC agreed on the following order of intensity based on anatomic region: Thoracic > Extremity > Abdomen.

The injection plane for thoracic blocks is deeper than the injection plane for lower extremity and abdominal blocks and involves more complicated anatomy. The proximity of vulnerable structures adjacent to the injection site, such as veins, pleura, and the intercostal arteries increases the risks associated with placing a thoracic block, even when using ultrasound guidance. While the pectoral nerve (PECS) block is more superficial compared to other types of thoracic blocks, the PECS block is no longer the most common thoracic block that is used in clinical practice. The other more typical thoracic blocks (e.g. Serratus block) are deeper. An ultrasound-guided thoracic fascial plane block also requires more specialized training and experience to recognize the ultrasound anatomy and achieve reliable results. A linear transducer is scanned at the sagittal plane along the midaxillary line to orient the 3rd and 4th ribs while visualizing the pleura, serratus anterior muscle, and path of the needle by the acute pain management physician who is placing a serratus anterior plane block.

The lower extremity fascial plane blocks are also more complex and intense than abdominal blocks. The specialties also noted that techniques for lower extremity fascial plane blocks are technically challenging. For example, with the suprainguinal fascia iliaca blocks, which have evolved as an effective means to provide analgesia to the hip, the sensory innervation of the hip is complex,

involving multiple nerves from both lumbar and sacral plexi. Placing this block requires specialized training and significant experience and understanding of ultrasound anatomy to encourage the adequate spread of the local anesthesia.

Unilateral Versus Bilateral; Single Injection Versus Continuous Infusion
The society presented information about expected differentiation in physician work for bilateral procedures and infusions. In each case this further supported the recommended values (by survey or crosswalk). The RUC agreed the survey should be used so long as the values were consistent with the expected differential. The RUC further agreed that use of intensity was of diminished value in short intra-service time procedures, but that the pattern of intensity did not substantially deviate from the expected intensities. Finally, the RUC assessed any physician time changes for the existing codes and concluded that the recommended RVUs were reasonably proportional, based on surveys. Overall, a consistent pattern was created across the services considered.

64466 ***Thoracic fascial plane block, unilateral; by injection(s), including imaging guidance, when performed***
The RUC reviewed the survey results from 51 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time.

To justify a work RVU of 1.50, the RUC compared the surveyed code to second key reference code 64415 *Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed* (work RVU = 1.50, intra-service time = 10 minutes, total time = 35 minutes) and noted that both procedures involve identical intra-service time and that 64466 was slightly more intense and complex to perform. As an additional reference, the RUC compared this service to CPT code 31579 *Laryngoscopy, flexible or rigid telescopic, with stroboscopy* (work RVU = 1.88, intra-service time = 10 minutes, total time = 34 minutes). **The RUC recommends a work RVU of 1.50 for CPT code 64466.**

64467 ***Thoracic fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed***
The RUC reviewed the survey results from 32 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.74 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 15 minutes of intra-service time and 10 minutes of immediate post-service time. The specialties noted that the additional 5 minutes of post-service time for the continuous infusion codes (compared to the injection codes) is intended to address the initial work to program the infusion pumps, including entering appropriate orders, programming, dosing, and locking the infusion pump. It also accounts for the time spent educating the patient on expectations related to the catheter infusion, including potential numbness, pump functions, signs of infection and the process for catheter removal. This work is typically performed by the acute pain management physician and acute pain team that is responsible for placing the fascial plane block.

To justify a work RVU of 1.74, the RUC compared the survey code to top key reference code 64416 *Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed* (work RVU= 1.80, intra-service time= 15 minutes, total time= 44 minutes) and 2nd key reference code 64461 *Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging*

guidance, when performed) (work RVU= 1.75, intra-service time= 15 minutes, total time= 44 minutes). The RUC noted that all three services involve identical intra-service and total time, and both reference codes support the recommendation. **The RUC recommends a work RVU of 1.74 for CPT code 64467.**

64468 ***Thoracic fascial plane block, bilateral; by injection(s), including imaging guidance, when performed***

The RUC reviewed the survey results from 49 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.67 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 14 minutes of intra-service time and 5 minutes of immediate post-service time. The specialties noted that bilateral blocks do not require twice as much intra-service time compared to unilateral blocks. The majority of the intra-service work is related to ultrasound imaging and identifying the appropriate fascial plane and the adjustment of the ultrasound machine to appropriately view the correct plane. Once the physician has performed the first side, the correct depth has been identified and the appropriate needle angle and trajectory has already been determined, thus allowing the physician to perform the second side more efficiently.

To justify a work RVU of 1.67, the RUC compared the surveyed code to 2nd key reference code 64415 *Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed* (work RVU = 1.50, intra-service time = 10 minutes, total time = 35 minutes) and noted that the surveyed code involves 4 more minutes of intra-service time and 2 more minutes of total time, thus is appropriately valued higher. The RUC also compared the surveyed code to CPT code 64448 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed* (work RVU = 1.68, intra-service time = 15 minutes, total time = 43 minutes) and noted that although the surveyed code involves slightly less time, it is more intense as described in the introductory paragraph. **The RUC recommends a work RVU of 1.67 for CPT code 64468.**

64469 ***Thoracic fascial plane block, bilateral; by continuous infusion(s), including imaging guidance, when performed***

The RUC reviewed the survey results from 30 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.83 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 6 minutes of pre-service scrub/dress/wait, 20 minutes of intra-service time and 10 minutes of immediate post-service time. The specialties noted that the additional 5 minutes of post-service time for the continuous infusion codes (compared to the injection codes) is intended to address the initial work to program the infusion pumps, including entering appropriate orders, programming, dosing, and locking the infusion pump. It also accounts for the time spent educating the patient on expectations related to the catheter infusion, including potential numbness, pump functions, signs of infection and the process for catheter removal. This work is typically performed by the acute pain management physician and acute pain team that is responsible for placing the fascial plane block.

The specialties noted that bilateral blocks do not require twice as much intra-service time compared to unilateral blocks. The majority of the intra-service work is related to ultrasound imaging and identifying the appropriate fascial plane and the adjustment of the ultrasound machine to appropriately view the correct plane. Once the physician has performed the first side, the correct depth has been identified and the appropriate needle angle and trajectory has already been determined, thus allowing the physician to perform the second side more efficiently.

To justify a work RVU of 1.83, the RUC compared the surveyed code to top key reference code 64416 *Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed* (work RVU = 1.80, intra-service time = 15 minutes, total time = 44 minutes) and 2nd key reference code 64461 *Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)* (work RVU = 1.75, intra-service time = 15 minutes, total time = 44 minutes). The RUC noted that the surveyed code involves 5 more minutes of intra-service time and 6 more minutes of total time relative to these two reference codes, therefore, is appropriately valued higher. **The RUC recommends a work RVU of 1.83 for CPT code 64469.**

64473 *Lower extremity fascial plane block, unilateral; by injection(s), including imaging guidance, when performed*

The RUC reviewed the survey results from 51 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.34 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 3 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time.

To justify a work RVU of 1.34, the RUC compared the survey code to top key reference code 64447 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed* (work RVU = 1.34, intra-service time = 8 minutes, total time = 29 minutes) and noted that the surveyed code requires similar physician time to perform, therefore supports the recommended value The RUC also compared the surveyed code to 2nd key reference code 64415 *Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed* (work RVU = 1.50, intra-service time = 10 minutes, total time = 35 minutes) and noted that both services involve identical intra-service time, whereas the reference code involves somewhat more total time, justifying a somewhat lower valuation for the surveyed code. **The RUC recommends a work RVU of 1.34 for CPT code 64473.**

64474 *Lower extremity fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed*

The RUC reviewed the survey results from 36 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.67 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 15 minutes of intra-service time and 10 minutes of immediate post-service time. The specialties noted that the additional 5 minutes of post-service time for the continuous infusion codes (compared to the injection codes) is intended to address the initial work to program the infusion pumps, including entering appropriate orders, programming, dosing, and locking the infusion pump. It also accounts for the time spent educating the patient on expectations related to the catheter infusion, including potential numbness, pump functions, signs of infection and the process for catheter removal. This work is typically performed by the acute pain management physician and acute pain team that is responsible for placing the fascial plane block.

To justify a work RVU of 1.67, the RUC compared the surveyed code to top key reference code 64448 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed* (work RVU =1.68, intra-service time = 15 minutes, total time = 43 minutes) and note that both codes require an identical amount of intra-service time and the surveyed code typically requires 1 more minutes of total time. The RUC also compared the surveyed code to second key reference code 64446 *Injection(s),*

anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed (work RVU = 1.75, intra-service = 15 minutes, total time = 44 minutes) and noted that both services involve identical intra-service and total time, supporting the recommended value for the surveyed code. **The RUC recommends a work RVU of 1.67 for CPT code 64474.**

64486 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)***
The RUC reviewed the survey results from 64 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.20, lower than the current work RVU, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time. The specialty societies noted that there has been dramatic growth in the number of acute pain teams across the country since the RUC reviewed the TAP block codes in 2014. At that time, fewer physicians had the specialized training to perform fascial plane blocks and adoption was therefore more limited. A decade later, that is no longer the case. The specialty societies noted and the RUC concurred that, since the work of the acute pain management physician and acute pain team that perform the fascial plane block is wholly separate from the work of the anesthesiologist and anesthetic team that is providing patient care in the operating room during surgery, there is no duplication in pre-service evaluation time and pre-service positioning time.

To justify a work RVU of 1.20, the RUC compared the surveyed code to 2nd key reference code 64447 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed* (work RVU= 1.34, intra-service time= 8 minutes, total time= 29 minutes) and noted that the surveyed code requires slightly more time though is slightly less intense to perform, thus appropriately valued lower. The RUC also reference CPT code 36584 *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement* (work RVU = 1.20, intra-service time = 12 minutes, total time = 34 minutes) and noted that although the surveyed code requires slightly less time, it is somewhat more intense to perform and overall both services require the same physician work to perform. **The RUC recommends a work RVU of 1.20 for CPT code 64486.**

64487 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)***
The RUC reviewed the survey results from 40 anesthesiologists and pain medicine physicians and determined that a work RVU of 1.39, lower than the current work RVU, appropriately accounts for the work required to perform this service. The RUC noted that the survey 25th percentile work RVU overestimated the work required to perform this service. Therefore, the RUC recommended a direct work RVU crosswalk to CPT Code 64445 *Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed* (work RVU = 1.39, intra-service time =10 minutes, total time = 24 minutes). The RUC recommends the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 12 minutes of intra-service time and 10 minutes of immediate post-service time. The specialties noted that the additional 5 minutes of post-service time for the continuous infusion codes (compared to the injection codes) is intended to address the initial work to program the infusion pumps, including entering appropriate orders, programming, dosing, and locking the infusion pump. It also accounts for the time spent educating the patient on expectations related to the catheter

infusion, including potential numbness, pump functions, signs of infection and the process for catheter removal.

The RUC also compared the surveyed code to top key reference code 64448 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed* (work RVU=1.68, intra-service time = 15 minutes, total time = 43 minutes) and noted that the surveyed code involves slightly less intra-service and total time. **The RUC recommends a work RVU of 1.39 for CPT code 64487.**

64488 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)***
The RUC reviewed the survey results from 62 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.40, lower than the current work RVU, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 12 minutes of intra-service time and 5 minutes of immediate post-service time. The specialties noted that bilateral blocks do not require twice as much intra-service time compared to unilateral blocks. The majority of the intra-service work is related to ultrasound imaging and identifying the appropriate fascial plane and the adjustment of the ultrasound machine to appropriately view the correct plane. Once the physician has performed the first side, the correct depth has been identified and the appropriate needle angle and trajectory has already been determined, thus allowing the physician to perform the second side more efficiently.

To justify a work RVU of 1.40, the RUC compared the survey code to top key reference code 64461 *Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)* (work RVU = 1.75, intra-service time = 15 minutes, total time = 44 minutes) and noted that the surveyed code requires less intra-service time and total time, therefore is appropriately valued lower. The RUC also compared the surveyed code to CPT code 27096 *Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed* (work RVU = 1.48, intra-service time = 11 minutes, total time = 38 minutes) and noted that the surveyed code requires 1 more minute of intra-service time but less lower total time and therefore is appropriately valued lower. **The RUC recommends a work RVU of 1.40 for CPT code 64488.**

64489 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)***
The RUC reviewed the survey results from 40 anesthesiologists and pain medicine physicians and determined the survey 25th percentile work RVU of 1.75, lower than the current work RVU, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 20 minutes of intra-service time and 10 minutes of immediate post-service time. The specialty societies noted that the additional 5 minutes of post-service time for the continuous infusion codes (compared to the injection codes) is intended to address the initial work to program the infusion pumps, including entering appropriate orders, programming, dosing, and locking the infusion pump. It also accounts for the time spent educating the patient on expectations related to the catheter infusion, including potential numbness, pump functions, signs of infection and the process for catheter removal. This work is typically performed by the acute pain management physician and acute pain team that is responsible for placing the fascial plane block.

The specialty societies noted that bilateral blocks do not require twice as much intra-service time compared to unilateral blocks. The majority of the intra-service work is related to ultrasound imaging and identifying the appropriate fascial plane and the adjustment of the ultrasound machine to appropriately view the correct plane. Once the physician has performed the first side, the correct depth has been identified and the appropriate needle angle and trajectory has already been determined, thus allowing the physician to perform the second side more efficiently.

To justify a work RVU of 1.75, the RUC compared the survey code to 2nd key reference code 64448 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed* (work RVU =1.68, intra-service time = 15 minutes, total time = 43 minutes) and noted that the surveyed code involves 5 more minutes of intra-service time and 6 more minutes of total time, supporting a higher valuation. The RUC also compared the surveyed code to CPT code 64463 *Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)* (work RVU = 1.90, intra-service time = 20 minutes, total time = 54 minutes) and noted that both services involve identical intra-service time, whereas the reference code involves 5 more minutes of total time, therefore is appropriately valued higher. **The RUC recommends a work RVU of 1.75 for CPT code 64489.**

Practice Expense
The Practice Expense Subcommittee discussed and approved compelling evidence based on error made in 2014 which inadvertently omitted supply SB019 *drape-towel sterile 18in x 26in* (quantity = 4) from unilateral codes 64486 and 64487. This supply is necessary in order to create a quadrant to block out the whole procedural field during all fascial plane block services, not just bilateral services. This supply item is currently included as a direct PE supply input (quantity = 4) for the bilateral single injection and continuous infusion TAP block codes (64488, 64489). The specialty societies recommended, and the Practice Expense Subcommittee agreed, that SB019 (quantity = 4) be included as a direct PE supply input for all 10 fascial plane block codes. The Practice Expense Subcommittee also adjusted the equipment minute formulas to properly compute for the code family and made minor adjustments to CA019 *Assist physician or other qualified healthcare professional--directly related to physician work time (67%)* for three of the unilateral codes (64466, 64473, and 64486). **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

<u>Magnetic Resonance Examination Safety Procedures (Tab 9)</u>
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At the September 2023 CPT Editorial Panel meeting, a new code family was created to describe magnetic resonance (MR) examination safety procedures and capture the physician work involving patients with implanted medical devices that require access to MR diagnostic procedures. Implanted medical devices or foreign bodies can increase the risk of injury or death for a patient entering the MR environment, either for diagnostic procedures or for procedures utilizing MR imaging guidance. Technological advancements in both the MR imaging (MRI) scanner and the design and testing of electronic implanted medical devices have expanded access to patients who were previously contraindicated for MR diagnostic and interventional procedures. CPT code 76016 describes MR safety planning services performed in advance of the date of the MR procedure, while 76017, 76018 and 76019 describe MR safety planning services performed on the day of the MR examination under the supervision of a physician or other qualified health care professional (QHP). This code family was surveyed for the January 2024 RUC meeting.

Due to the wide range of implanted devices to consider with these safety procedures before an MR examination, the CPT Editorial Panel designed this code family to reflect the wide breadth of implanted device heterogeneity. In the preliminary discussion of this tab, the specialty societies explained that the complex structure of this code family is attributable to the codes being modular, in that each service is distinctly independent and completed separately from one another. The relationship of relative value within this code family is determined by the complexity of work, not its clinical description. The RUC agreed with this clarification and accounted for there not being a typical rank order within this code family in their analysis and valuation of each service.

The CPT Editorial Panel designated 76017, 76018 and 76019 to be Modifier -51 Exempt, as these procedures protect the patient from harm associated with the presence of an implanted device and are independent of the work associated with the performed MR examination. Likewise, the modular design of 76017, 76018 and 76019 ensures there is no duplicated work between the three codes in the occasional instances multiple codes might be required for a particular implanted device. The valuation, time and PE recommendations are above and beyond the MR service; any reduction for multiple procedures would be inappropriate. Furthermore, the RUC determined it most appropriate to break out the pre-, intra- and post-service times for all four surveyed codes in this family using the RUC survey results. The RUC recognized that this decision would help align the work RVU recommendations of physician work with the detailed descriptions of pre-, intra- and post-service work provided by the specialty societies.

76014 ***MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes***

76015 ***MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)***

CPT codes 76014 and 76015 are practice expense only services that represent the preparatory research and review completed by clinical staff (i.e., MRI technologist and/or a medical physicist) that will be utilized by the physician or QHP for the other four services in this code family.

76016 ***MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR exam, analysis of risk versus clinical benefit of performing MR exam, and determination of MR equipment, accessory equipment, and expertise required to perform examination with written report***

The RUC reviewed the results from 57 radiologists and neuroradiologists and determined the survey 25th percentile work RVU of 0.60 appropriately accounted for the physician work required to perform this service. The RUC recommends 15 minutes pre-service evaluation time, 5 minutes intra-service time and 5 minutes post-service, equaling 25 minutes total time.

This procedure involves MR safety determination by a physician or QHP responsible for the appropriateness and safety of the MR procedure. During the pre-service time period, preparation for

the MR safety determination will occur. The MR technologist or MR Safety Officer will obtain the patient's clinical history, relevant implanted device details/instructions, and MR conditional labeling. The radiologist and medical physicist will conduct a comprehensive risk analysis assessing the potential risk to the patient versus clinical benefit using these materials based on several factors including but not limited to (1) information prepared in the pre-service time related to the implanted device limitations; (2) proximity of the implanted device/foreign body to sensitive tissues and; (3) evaluation of the potential clinical risk to the patient in the event of device malfunction or injury during the procedure. During the intra-service time period, the MR exam parameters are reviewed for conformance with the implanted device safety instructions, a decision regarding whether informed consent should be obtained before the MR exam is made and alternative recommendations or testing are considered that would utilize accessory equipment to safely perform the MR exam. During the post-service time period, communication with the patient and completion of a technical report will detail the recommendations, special precautions, and expectations for the MR exam as specified by the radiologist and medical physicist.

To support the recommended work RVU value of 0.60, the RUC compared the surveyed code to the top key reference service 93286 *Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system* (work RVU = 0.30, 10 minutes intra-service time and 22 minutes total time) and second key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93, 15 minutes intra-service time and 20 minutes total time). While the surveyed code is like CPT code 93286 in that there is an assessment of a device before the procedure, the assessment required in 76016 is more complex due to the risk/benefit analysis and overall breadth of medical decision-making. In comparison to CPT code 99202, the surveyed code is less intense but similar in that the physician will be reviewing the medical record for prior imaging, clinical history, and reason for study, which will lead to a decision regarding the risk/benefit of performing the MR scan. Thus, the work RVU valuation of CPT code 76016 is appropriately bracketed by the top two chosen key reference services, CPT codes 93286 and 99202.

The RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69, 10 minutes intra-service time and 23 minutes total time) and determined that these services require a similar amount of physician work and time to perform, thus support the recommended value of 0.60 for CPT code 76016. **The RUC recommends a work RVU of 0.60 for CPT code 76016.**

76017 ***MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies with written report***

The RUC reviewed the results from 38 radiologists and neuroradiologists and determined the survey 25th percentile work RVU of 0.76 appropriately accounted for the physician work required to perform this service. The RUC recommends 14 minutes pre-service evaluation time, 10 minutes intra-service time and 5 minutes post-service, equaling 29 minutes total time.

This procedure involves MR safety medical physics examination customization, preparatory planning, and intra-service performance monitoring. During the pre-service time period, a review of the implant-related MR exam constraints will take place between the radiologist and medical physicist or MR Safety Officer. In reviewing what the radiologist has protocoled, the medical physicist or MR safety expert will develop examination customization based on several factors including but not limited to (1) identification of potentially problematic imaging sequences that have too high of radiofrequency (RF) energy levels being deposited; (2) prioritization of select views and imaging sequences to ensure diagnostic quality and anatomical coverage and; (3) modification of customization mid-procedure based on back-and-forth feedback from the radiologist regarding image contrast or the patient's total scan time restrictions. During the intra-service time period, the radiologist will review imaging in real-time during the MRI acquisition, which has been customized and tailored to restrictive requirements based on the patient's condition and implant-related limitations as determined during the pre-service work. Scan parameter adjustments are conducted as necessary. During the post-service time period, the technical report from the medical physicist or MR safety expert will be recorded.

The RUC compared the surveyed code to MPC codes 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time and 26 minutes total time) and 88305 *Level IV - Surgical pathology, gross and microscopic examination…* (work RVU = 0.75, 25 minutes intra-service and total time). The RUC recognized that these services require similar physician work and time, thus supporting the recommended value of 0.76 for 76017. In comparison to the surveyed code, the RUC noted that both MPC reference services involve similar examination and assessment of a patient's clinical history and diagnostic studies when making case-specific medical decisions about the next steps in imaging or treatment.

For additional support, the RUC referenced the second key reference service 72125 *Computed tomography, cervical spine; without contrast material.* (work RVU = 1.00, 12 minutes intra-service time and 22 minutes total time). This reference service describes physician work that involves modification of MR imaging parameters and prioritization of the order of MR sequences to ensure a quality diagnostic exam. The RUC acknowledged that CPT code 72125 requires slightly less total time than the surveyed code, however, it is more intense since the typical patient is an emergency room (ER) patient with concern for neck injury. **The RUC recommends a work RVU of 0.76 for CPT code 76017.**

76018 ***MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room with written report***

The RUC reviewed the results from 38 radiologists and neuroradiologists and determined that a work RVU of 0.75 appropriately accounted for the physician work required to perform this service. The RUC recommends 12 minutes pre-service evaluation time, 8 minutes intra-service time and 5 minutes post-service, equaling 25 minutes total time.

This procedure involves MR safety implant electronics preparation, including MR-specific programming of a pulse generator and/or transmitter. During the pre-service time period, confirmation of the type, necessary configuration, and programming instructions for the patient's

active electronic implanted device occurs. The MR-specific programming considers the risks of programming modes, implant malfunction, and interruption of therapy regarding patient tolerance. During the intra-service time period, real-time monitoring of the patient's tolerance and side effects of the modified therapies will occur to determine whether or not it is appropriate to proceed with the MR exam. During the post-service time period, the technical report from the medical physicist or MR Safety Officer will be recorded and follow-up with the patient's treating physician will be requested if the implanted device does not return to the status observed before the MR exam.

To support the recommended work RVU value of 0.75, the RUC compared the surveyed code to the top key reference service 93287 *Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system* (work RVU = 0.45, 10 minutes intra-service time and 25 minutes total time) and second key reference service 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 23.5 minutes total time). While the surveyed code is like CPT code 93287 in that there is an assessment of a device before the procedure, there is a greater complexity and intensity of work involved with 76018 as an implanted device will be exposed to MRI rather than only a device check in pre- or post-procedure. In comparison to CPT code 93289, the surveyed code has the same work RVU valuation and requires similar time and almost identical intensity. Notably, 76018 is slightly more complex due to its interrogation of a device under normal conditions versus taking care of a device in a conditional mode inside a magnet that could potentially impact the device and the patient's condition. Thus, the work RVU valuation of CPT 76018 code is appropriately bracketed by the top two key reference services, CPT codes 93287 and 93289.

For additional support, the RUC referenced MPC codes 88305 *Level IV - Surgical pathology, gross and microscopic examination…* (work RVU = 0.75, 25 minutes intra-service and total time) and 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time and 26 minutes total time), which require the same physician work and time to perform. **The RUC recommends a work RVU of 0.75 for CPT code 76018.**

76019 ***MR safety implant positioning and/or immobilization under supervision of physician or qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room with written report***

The RUC reviewed the results from 32 radiologists and neuroradiologists and determined that a work RVU of 0.60 appropriately accounted for the physician work required to perform this service. The RUC recommends 15 minutes pre-service evaluation time, 10 minutes intra-service time and 5 minutes post-service, equaling 30 minutes total time.

This procedure involves MR safety implant positioning and immobilization under the supervision of a physician or QHP. During the pre-service time period, the physician or QHP will assess the risks and benefits associated with immobilization and if determined appropriate. Other preparatory actions are completed, notably, the physical location of the affected implant will be identified and/or marked on

the patient's skin. During the intra-service time period, the application of physical protections to secure the implanted medical device from MR-induced translational or vibrational forces, magnetically induced changes, and/or prevent potential radiofrequency burns from inadvertent tissue contact while the MR room occurs. Assessing the patient's pain tolerance and discomfort at the site of the implant will determine MR exam discontinuation or completion. An inspection for evidence of implant migration, malfunction or tissue damage is conducted upon exiting of the MR scan room. During the post-service time period, the technical report from the medical physicist or MR Safety Officer will be recorded and follow-up with the patient's treating physician will be requested if the implanted device does not return to the status observed before the MR exam.

To support the recommended work RVU value of 0.60, the RUC compared the surveyed code to the second key reference service 93286 *Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system* (work RVU = 0.30, 10 minutes intra-service time and 22 minutes total time) and CPT code 93287 *Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system* (work RVU = 0.45, 10 minutes intra-service time and 25 minutes total time). The RUC recognized that the surveyed code requires more physician work than CPT code 93286 attributable to preparing the patient and their implantable device before entering the magnet, ensuring appropriate patient positioning while in the magnet, and monitoring the safety of the implantable device during the scan. While the surveyed code is like CPT code 93287 in that there is an assessment of a device before the procedure, there is a greater complexity and intensity of work involved with 76019 as an implanted device will be exposed to MRI rather than there just being a device check pre- or post-procedure.

The RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69, 10 minutes intra-service time and 23 minutes total time) and determined that these services require similar physician work and time to perform, thus support the recommended value of 0.60 for CPT code 76019. **The RUC recommends a work RVU of 0.60 for CPT code 76019.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the practice expense inputs for CPT codes 76014–76019 and made one modification to adjust the clinical staff time involved with code 76015. For this code, CA021 *Perform procedure/service---NOT directly related to physician work time* has two clinical staff types, L047A *MRI Technologist* and L152A *Medical Physicist*. L047A increased from 26 to 27 minutes, resulting in 45 minutes of total clinical staff time for CA021. The specialty societies confirmed that both the technologist and the medical physicist are reviewing existing imaging on the technologist PACS workstation, sometimes sequentially on the same tech PACS workstation and sometimes in parallel at two separate PACS workstations. The PE Subcommittee also acknowledged the new equipment input, *Vitals monitoring system (MR Conditional)*, and the two new supply inputs, *Thermoplastic splint material 6"x9" (MR Safe)* and *Disposable oximeter probe and clip (MR Conditional)*, as recommended for codes 76018 and 76019. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Committee.**

New Technology

CPT codes 76014, 76015, 76016, 76017, 76018 and 76019 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.

Modifier -51 Exempt
The RUC recommends that CPT codes 76017, 76018 and 76019 be added to the Modifier -51 Exempt list. These procedures are typically performed with another procedure but may be stand-alone procedures and not always performed with other specified procedures. The valuation, time and PE recommendations provided by the specialty societies distinguished the work associated with these three codes from the work of the MR service and focused the work of each code on the distinct requirements of an implanted device. There are currently no identified implanted devices with FDA-approved labeling requiring both 76018 and 76019 procedures to be performed before an MRI.

Genetic Counseling Services (PE Only) (Tab 10)
Carolyn Dinsmore Applegate, CGC, MGC (ACMG), Rachel Bluebond, MMSc, CGC (ACMG), Howard Levy, MD (ACMG), Brian Reys, MS, CGC (ACMG)

In September 2023, the CPT Editorial Panel deleted CPT code 96040 and created a new CPT code for medical genetics and genetic counseling services to be provided by the genetic counselor. CPT code 96041 describes medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter. For CPT code 96041, the services are provided by trained genetic counselors and may include obtaining a structured family genetic history, pedigree construction, analysis for genetic risk assessment and counseling of the patient and family. A physician or other qualified healthcare professional (QHP) who may report evaluation and management services would not be able to report 96041. Instead, these physicians and QHPs would use the appropriate evaluation and management code.

Genetic counselors are not recognized as qualified healthcare professionals by CMS and consequently cannot bill Medicare directly. Therefore, 96041 is a practice expense only code. Practice expense recommendations were developed for the January 2024 RUC meeting accordingly.

Practice Expense Only Custom RUC Survey
In preparation for the January 2024 RUC meeting, the American College of Medical Genetics, collaborating with the National Society of Genetic Counselors, determined that it would be appropriate to conduct a practice expense survey for 96041 and submitted a proposal for the Research Subcommittee's consideration. The societies noted that Genetic counselors (GCs) are regularly assisted by genetic counselor assistants (GCAs) and that they wanted to use the survey to help determine whether the use of a GCA is typical.

The Research Subcommittee agreed that the PE-only custom survey template should capture both GC time and GCA time. The custom survey template instructed survey respondents to estimate their time for an entire patient encounter, so the survey respondents would not be asked to prorate their time estimates across multiple units of the code. The custom template also only included clinical activities that the societies believed to be typical. The service period was defined as the entire date of the patient encounter, mirroring other CPT codes that are reported based on time on the date of the patient encounter (i.e. E/M services). The survey results were adjusted to reflect a single unit of 96041, which is reported for each 30 minutes of total time provided by the genetic counselor on the date of the encounter. These data were also used to help determine the typical number of units for 96041.

Compelling Evidence
The Practice Expense (PE) Subcommittee initially agreed with the specialty society that there is compelling evidence to support an increase over the aggregate current cost of the direct inputs for new code 96041 as compared to deleted code 96040. The PE Subcommittee concurred that the main drivers for compelling evidence are changes in genetic counselor work due to changes in knowledge/technology and patient population. From 2006 to 2023, the predominant genetic counselor practice setting shifted from prenatal to oncology, indicating a change in the patient population. The specialty attested to the modernization of equipment costs since the valuation of code 96040 in 2005. A contributing factor to the change in technology is the utilization of pedigree software; however, the PE Subcommittee removed the software from the recommended inputs as it is considered an overhead/indirect expense.

New Clinical Labor Staff Type
The PE Subcommittee agreed that CPT code 96041 represents the increased complexity of genetic counseling, requiring slightly more clinical staff time and a new additional typical clinical staff type. The new staff type, a genetic counseling assistant, performs different activities than the genetic counselor and the genetic counseling assistant's time is not included in the number of units of 96041 that the genetic counselor will report. The genetic counseling assistant clinical staff type was not typical in 2005 but survey data now support this clinical staff type as part of the typical genetic counseling service with 54% of respondents reporting genetic counseling assistant time. The genetic counselor and the genetic counseling assistant work in tandem with the genetic counseling assistant supporting the genetic counselor practice. Genetic counseling assistant activities may fit in the same clinical activity code as genetic counselor activities, but the level and detail of these tasks are different. For example, the genetic counseling assistant will review medical records to identify missing information, begin summarizing pertinent information and build a patient specific pedigree, while the genetic counselor also reviews records, expands details in the pedigree before, during, and/or after the patient encounter, and documents all findings, observations, risk assessments and plans. The specialty provided supportive documentation for the new clinical labor staff type, and the PE Subcommittee recommends the use of a Genetic Counseling Assistant using L039B *Physical Therapy Assistant* as an appropriate proxy that is listed by the Bureau of Labor Statistics (BLS).

Considering the typical number of units of 96041 reported per session is three, the PE Subcommittee discussed the direct practice expense inputs with the understanding that the clinical activity minutes will be multiplied by three when the typical number of units is reported. The Subcommittee detailed the clinical activities to determine the exact work of the genetic counselor versus the genetic counseling assistant and to ensure there was no duplication in the standard inputs. Since both staff types are considered "clinical staff," the Subcommittee worked to ensure there is no overlap in clinical staff activities and subsequently made several reductions to the pre-service and post-service times. For example, the number of post-service phone calls was reduced from 6 minutes to 2 minutes given the multiplier of 3 (2 x 3 = 6 minutes), providing for the equivalent of two standard 3-minute phone calls or one complex call, as described by the specialty, in the post-service period. The intra-service time for the genetic counselor was increased from 14 to 20 minutes such that the total genetic counselor time for the service period would equal 30 minutes. The PE Subcommittee recommends a total clinical staff time of 57 minutes per unit of CPT code 96041 including 46 minutes of genetic counselor time and 11 total minutes of genetic counseling assistant time.

New Clinical Staff Activities
The reference code 96040 predated the use of clinical activities (CA) codes. The PE custom survey was mapped to existing CAs; however, there was one clinical activity in the survey instrument that did not map to any existing activity, *Collect/Update personal and family history/pedigree*. The specialty explained that constructing a genetic family history and developing a pedigree is very

different from obtaining a regular family history. The PE Subcommittee agreed with the specialty's request that a new CA code be created for this pre-service period activity:

- *Collect/Update personal and family history/pedigree*: Collecting a genetic personal and family history is a distinct clinical activity from typical family history collection performed by other specialists. Multiple societies including the American College of Medical Genetics, National Society of Genetic Counselors, and the National Comprehensive Cancer Network have recommendations that include typical family history collection for genetic evaluation extending to 2nd & 3rd-degree relatives (aunts/uncles, cousins, great aunts/uncles, etc.) which is not common practice amongst non-genetics specialties. Additionally, family history collection performed via pedigree is more detailed, as it involves collection and analysis per-relative instead of per-condition. History collection this way is known to increase the identification of appropriate patients for genetic testing, however, it is time intensive compared to the typical family history taken for non-genetics specialties.

In addition, during the discussion of the post-service activities, it became apparent that two additional new CA codes were needed to delineate the post-service of the service period activities, CA028 *Review/read post-procedure x-ray, lab and pathology reports* and CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.),* from the post-service period activities in this service. The PE Subcommittee agreed to create new CA codes for the following activities in the post-service period and designated 4 minutes for each of these new activities to the genetic counselor:

- *Review Genetic/Follow Up Test Results*: This new clinical activity includes review of genetic and other follow-up test results received after the date of service. Genetic test results typically identify one or more variants, which require further evaluation by the genetic counselor. This includes researching and assessing these findings in clinical databases (e.g. ClinVar, ClinGen, gnomAD) prior to communicating results to the patient, family, and medical team. This review determines the presence or absence of prior reports of the identified variant(s), and when present, also includes the associated classification of such variant(s) as these classifications may vary between laboratories. Critically, this review includes comparison to any other interpretations of identified variant(s) that may differ from that of the patient's report and/or have been previously provided to the patient's family. Variant interpretation and classification directly impact clinical management.

- *Correspondence Regarding Genetic/Follow Up Test Results*: This new clinical activity was created to help clarify that this type of correspondence and documentation is specifically related to that which occurs after genetic testing and other results are completed, received, and reviewed in the post-service period. This includes medical documentation, communicating the results to the healthcare team, and writing patient/family letters to facilitate communication of results amongst at-risk family members. Genetic counseling documentation is noted to be particularly detailed given the comprehensive review occurring in the new clinical activity described above and therefore, requires significant time.

The PE Subcommittee also reviewed the medical supply and equipment inputs and made several modifications. The typical patient was confirmed to be an adult patient, so SK048 *measuring tape, paper* for head circumference was removed as was SA048 *pack, minimum multi-specialty visit* which

is not typical for this service in the non-facility office setting. Moreover, the new supply recommendation for *Pedigree Subscription, Cloud Based* software was removed as it is not allocable to a single patient and the Subcommittee concurred that the annual subscription is an overhead/indirect expense like a variety of other licenses, subscriptions, etc. Similarly, equipment input ED038 *notebook (Dell Latitute D600)* was removed as it is deemed an indirect expense that is generically usable for a broad range of services. Equipment item EF023 *table, exam* is also not typical for this counseling service and was deleted.

The specialty society confirmed that genetic counselors often contract with hospitals. Ultimately, the PE Subcommittee determined that the facility inputs should be removed completely from the recommendation for CPT code 96041 as the genetic counselor/private practice would need to contract with the institution when the service is performed in the facility setting.

The RUC recommends the non-facility direct practice expense inputs as modified by the Practice Expense Subcommittee including a request for a new clinical labor type, *Genetic Counseling Assistant*.

The RUC also approved the creation of the following 3 new clinical staff activity codes:

Collect/Update personal and family history/pedigree **(pre-service period)**
Review Genetic/Follow Up Test Results **(post-service period)**
Correspondence Regarding Genetic/Follow Up Test Results **(post-service period)**

X. CMS Request/Relativity Assessment Identified Codes

<u>Therapeutic Apheresis and Photopheresis (PE Only) (Tab 11)</u>
Elizabeth Blanchard, MD (ASCO), Elizabeth Godbey, MD (CAP), Chase Hendrickson, MD (ES), Amar Kelkar, MD (ASH), Ronald McLawhon, MD (CAP), Roger McLendon, MD (CAP)

In the Final Rule for 2024, CMS received a public nomination that CPT codes 36514, 36516 and 36522 may not include the correct clinical labor type. CMS agreed that there may be a disparity with the clinical labor type for this service and that these codes would benefit from additional review in future rulemaking. Therefore, for CY 2024, CMS finalized CPT codes 36514, 36516, and 36522 as potentially misvalued, resulting in a review of the practice expense clinical labor type at the January 2024 RUC meeting.

Compelling Evidence
The Practice Expense (PE) Subcommittee discussed and approved compelling evidence based on a change in the clinical labor type for these services, as the RN/LPN labor category is not adequately equivalent to an Apheresis Nurse Specialist. In the CY 2024 Final Rule, CMS agreed there may be a disparity with the clinical labor type for these services, and the codes would benefit from additional practice expense review. CMS also noted it is likely the RN/LPN labor category is not adequately equivalent to an Apheresis Nurse Specialist. While an apheresis nurse is not currently a category listed in the Medicare Physician Payment Schedule (MFS), there may be existing nurse categories that may be an appropriate substitute, such as an oncology nurse (RN/OCN). **The Practice Expense Subcommittee and RUC accepted compelling evidence based on evidence that there has been a change in the clinical labor type.**

Clinical Labor Type
The PE Subcommittee and the RUC agreed with the specialty societies' recommendation to use clinical labor type L056A *RN/OCN* as a proxy to recognize the work of an apheresis nurse. The

specialty societies noted that they considered proposing a new clinical staff type for an Apheresis Nurse Specialist, but decided against this, as there is not a Bureau of Labor Statistics labor category for an apheresis nurse, and apheresis nurse wage survey data is not readily available. Instead, the specialties proposed to use the oncology nurse (*RN/OCN*) clinical labor type to recognize the work of an apheresis nurse. The specialty societies reiterated that CMS had expressed support for this crosswalk in the Final Rule, and it is also supported by similar training and experience requirements necessary for an apheresis nurse and an RN/OCN. To become an RN/OCN, a candidate must be an RN with a minimum of 2 years of experience, have a minimum of 2,000 hours (1 year) of adult oncology nursing practice within the past four years and have completed a minimum of 10 contact hours of nursing continuing education in oncology or an academic elective in oncology nursing within the past three years.

Additionally, the Qualification in Apheresis (QIA) was introduced in 2016, the year in which specialties were preparing for the last valuation of these codes at the January 2017 RUC meeting. The American Society for Apheresis (ASFA) in partnership with the American Society for Clinical Pathology (ASCP) Board of Certification, offers a Qualification in Apheresis (QIA). There are multiple pathways for obtaining a QIA, but the primary pathway is an RN, LPN, or licensed vocational nurse (LVN) with a U.S. state license, certificate, or diploma, and three years of full-time acceptable experience in apheresis or five years of part-time acceptable experience in apheresis within the last ten years. The specialty societies and the Practice Expense Subcommittee agreed to use the oncology nurse (RN/OCN) clinical labor type to recognize the work of an apheresis nurse.

Service Period Clinical Activities
The specialty societies recommended an additional correction to the clinical labor current inputs, which would not impact the amount of clinical labor time. The specialty societies noted that the minutes in CA018 *Assist physician or qualified healthcare professional – directly related to physician work time (100%)*, would more appropriately be categorized as CA021 *Perform procedures/service-NOT directly related to physician work time*. The error occurred when the clinical labor tasks were combined into their new categories after 2017.

The PE Subcommittee and the RUC agreed with the specialty societies' recommendations for CPT codes 36514, 36516 and 36522 to modify the clinical staff labor type to L056A and to shift the intra-service time to CA021. Further, they agree that the other direct PE inputs reviewed in January 2017 are all still appropriate. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

<u>Insertion of Tunneled Centrally Inserted Central Venous Catheter (Tab 12)</u>
Curtis Anderson, MD (OEIS), Wayne Causey, MD (SVS), Minhajuddin Khaja, MD (SIR), Lauren Nicola, MD (ACR), Don Selzer, MD (ACS), Richard Weiss, MD (APSA)

In April 2023, the Relativity Assessment Workgroup (RAW) identified CPT code 36558 via the site of service anomaly screen, for services with Medicare utilization over 10,000 in 2019-2021 that are typically performed in the inpatient hospital setting, yet only include a half discharge day management visit (99238). The RAW reviewed the action plan in September 2023, and agreed with the specialty societies that the entire family of services (36557-36566) be surveyed for the January 2024 RUC meeting. The specialty societies also requested changing the global period from a 010-day to a 000-day to account for variability in site of service based on the patient presentation and specialty performing the procedure.

However, when the specialty societies were preparing to survey the services, they determined they could not proceed and instead requested to revise the codes through the CPT process prior to surveying. The specialty societies noted that the ages listed within some of the current code descriptors do not accurately reflect the variation of physician work (e.g., babies versus infants versus children versus adults). Additionally, some of the code descriptors are antiquated and include outdated practices and techniques technology that no longer exist or are incorrectly described, which may cause incorrect reporting. For example, patients are receiving central lines at multiple points in time with no way to accurately and appropriately capture work based on the current code family structure. Finding an access location in a patient in which access issues have become harder, takes more time, includes more risk, and potentially requires additional interventions.

The RUC recommends that CPT codes 36557, 36558, 36560, 36561, 36563, 36565, and 36566 be referred to the May 2024 CPT Editorial Panel meeting for revision.

Insertion of Cervical Dilator (Tab 13)
Jon Hathaway, MD (ACOG), Eilean Attwood, MD (ACOG)

In the Medicare Physician Payment Schedule (MFS) Final Rule for CY 2024, CMS received a public nomination that the physician work and practice expense supply inputs for CPT code 59200 are not aligned with what is typically required to provide this service. CMS agreed with commenters that CPT code 59200 is a potentially misvalued service and warrants a comprehensive review since the code has not been reviewed in 20 years and the current typical practice of this code has evolved since then. CMS believed that CPT code 59200 could benefit from a review of its supply, equipment, and clinical labor items in addition to physician work RVUs and physician work times. Therefore, based on the information provided by commenters regarding the outdated nature of the code and supply input pricing, CMS finalized CPT code 59200 as potentially misvalued for CY 2024. The RUC reviewed the work and practice expense inputs for this service at the January 2024 meeting to allow CMS to consider these recommendations in the Proposed Rule for 2025.

Compelling Evidence
The specialty societies presented compelling evidence to support a change in physician work for the insertion of a cervical dilator based on a change in knowledge/technology. Studies have found that there was a significant improvement in maternal and fetal outcomes with elective induction of labor at 39 weeks over expectant management with induction of labor at 41 weeks if no spontaneous labor occurred. The impact of these findings has changed the counseling and management of pregnant women. Prior to this, it was thought that induction of labor (IOL) resulted in more cesarean deliveries and a higher risk of obstetrical comorbidities. In 1990, the induction rate was 9.6% but now stands at 32% and is even higher for first-time pregnancies. With this increase in IOL, most notably being manual dilation of the cervix (ie, cervical ripening), the procedure has moved from the hospital to the outpatient setting prior to admission. Given that several studies demonstrate the effectiveness of outpatient cervical ripening, regardless of method (ie, mechanical or pharmaceutical), the specialty society recommends that this change in patient population has changed the physician work and method in which this service is delivered. **The RUC accepted compelling evidence based on a change in knowledge/technology.**

59200 ***Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)***
The RUC reviewed the survey results from 291 obstetricians and gynecologists and recommends a work RVU of 1.20 based on the survey 25th percentile, which maintains relativity within the MFS. The RUC recommends 7 minutes of pre-service evaluation time, 3 minutes positioning time, 1 minute scrub/dress/wait time, 9 minutes intra-service time and 5 minutes immediate post-service time,

equaling 25 minutes total time. The majority (68%) of survey respondents agreed that the typical patient for this service is gravida 1 (G1) at 39 weeks gestation who presents for induction of labor, and an insertion of a cervical dilator is performed. A quarter of survey respondents indicated that the typical patient would represent a patient presenting for dilation and evacuation (D&E). The specialties clarified, and the RUC agreed, that for both of these vignettes the procedure is identical and requires the same physician work although the description of the patient may differ.

For this service, once the patient is in dorsal lithotomy position and draped, a sterile speculum is placed and positioned until the cervix is fully visualized. The cervix is then cleaned with sterile solution and a ring forceps is used to stabilize and manipulate the cervix. The dilator(s) are then carefully placed into and through the cervix such that the entire cervical length is affected, and the dilator is secured into place. Hemostasis is observed and the speculum is removed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)* (work RVU = 1.21, 10 minutes intra-service, and 25 minutes total time) and 11981 *Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)* (work RVU = 1.14, 5 minutes intra-service, and 30 minutes total time). The key reference services appropriately bracket the surveyed code work RVU given that the intra-service time is similar to code 58100 and higher than code 11981. Specifically, code 58100 is an excellent comparator given that the physician work is similar to the surveyed code with the procedure being the same except for the pipel and tissue being removed instead of the dilators remaining in place. Therefore, the RUC recommended value supports relativity when compared to similar services.

For additional support, the RUC compared the surveyed code to MPC code 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, 15 minutes intra-service, and 27 minutes total time). The intra-service time and total time are slightly lower when compared to the MPC code, therefore supporting the RUC recommended work RVU value of 1.20. **The RUC recommends a work RVU of 1.20 for CPT code 59200.**

Practice Expense

The Practice Expense (PE) Subcommittee discussed and accepted compelling evidence based on:

1. Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in the clinical staff time, supplies and equipment due to physician time; and
2. Evidence that there has been a change in equipment or practice expense cost.

For the first compelling evidence argument, the PE Subcommittee agreed with the increase in intra-service time and subsequent increase in physician time and noted that it is the current standard of care to have clinical staff assisting with the procedure 100% of the time for vaginal procedures. For the second argument, the RUC survey instrument included questions regarding the typical cervical dilator type and typical number of dilators used in the non-facility setting. The survey results indicated that the typical dilator type remains laminaria, however, the typical number of dilators used was reported as 5 instead of the current number of 3 dilators.

The PE Subcommittee reviewed the direct practice expense inputs and made one modification to increase CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient* from the standard of 2 minutes to 5 minutes as the patient needs to be in the dorsal lithotomy position. The PE Subcommittee acknowledged the existing supply input SA051 *pack, pelvic exam* which is priced at $20.16 yet the sum of its four components totals $2.81. The RUC continues to call on CMS to initiate

correction of the packs pricing such that the sum of the individual components matches the price of the corresponding pack. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

XI. Research Subcommittee (Tab 14)

Doctor Margie Andreae, Chair, provided the report of the Research Subcommittee.

- **Minutes, February 20 Research Subcommittee Specialty Requests Meeting Report Review**
  The Research Subcommittee report from the October 10th conference call included in Tab 14 of the January 2024 agenda materials was approved without modification.

- **Site-of-Service RUC Survey Question**
  During the January 2023 RUC New Business discussion, the RUC referred review of the site-of-service questions in the standard 000-day, 010-day and 090-day RUC survey template to the Research Subcommittee. The Subcommittee had a preliminary discussion on this top in April 2023. For the January 2024 meeting, the Chair and AMA RUC staff prepared two separate options for the Research Subcommittee's consideration. The first option instructed respondents to estimate the percentage of time they perform the service in the office, ASC and hospital settings. The second option was similar to the existing site of service questions, with the addition of asking the respondent to answer the questions based on the patient described in the survey vignette. Research Subcommittee members observed that the standard survey questions related to physician work and time direct the respondent to base their answers on the patient in the vignette, and the proposed change in the second option would align with these other questions. It was also observed that this change would allow the RUC to review the data based on the typical patient (assuming the patient in the vignette is typical). The site of service questions currently direct the respondent to base their answers on their typical experience which may not necessarily match the patient in the vignette.

  The Research Subcommittee approved for the site of service questions and summary of recommendation (SOR) form to use the following text for the 000-day, 010-day and 090-day standard RUC survey instruments:

  Question 2c) Post-Operative Work

  Please respond to the following questions for the survey code(s) <u>based on the typical patient described in the vignette(s) below</u>.

  [codes, descriptors, vignettes and globals displayed]

  Where do you perform this procedure for the typical patient?

  - **Typically performed at a hospital**
  - **Typically performed in an ASC**
  - **Typically performed in an office**

  [Displayed for those that selected hospital:]

  When do you discharge the patient?

  - **The same day as the procedure**

- **After an overnight stay-less than 24 hours**
- **After an overnight stay-more than 24 hours**

[Displayed for those that selected overnight stay:]
After the patient is transferred from the recovery room, do you or a qualified healthcare professional evaluate and examine the typical patient on the floor or other hospital unit later on the same day? Yes/No

Corresponding Changes to RUC Summary of Recommendations (SOR) form:

Site of Service (Complete for 000, 010 and 090 Globals Only)
Percent of survey respondents who stated they perform the procedure for the typical patient; In the hospital 0% , In the ASC 0%, In the office 0%

Of those survey respondents that stated they perform this procedure for the typical patient in the hospital, the percent of respondents who stated the patient is discharged: The same day 0%, Overnight stay-less than 24 hours 0)%, Overnight stay-more than 24 hours 0%

Of those survey respondents that keep the typical patient overnight, __ percent stated they perform an E&M service later on the same day

- **Discussion – Physician Work Intensity**
  During the RUC's *New Business* discussion at the April 2023 RUC meeting, a RUC member inquired about the value of intensity and how that impacts the adjudication of services. As part of this discussion, another RUC member requested that the Research Subcommittee review the intensity and complexity questions on the RUC survey to better reflect how intense/complex a given procedure is relative to other procedures in the MFS. The request was referred to the Research Subcommittee for discussion.

  The Subcommittee discussed the current intensity and complexity questions in the survey instrument briefly. During the discussion, AMA RUC staff noted that the background definitions for time, mental effort and judgement, technical skill, physical effort and psychological stress came from the Centers for Medicare & Medicaid Services (CMS) and could only be changed by CMS via rulemaking. Some Subcommittee members suggested the creation of an Ad Hoc Workgroup to explore the survey intensity and complexity questions. The Chair noted that this topic was most recently considered by the Subcommittee in January 2021 and at that time, the Subcommittee decided that no changes were necessary. Instead of forming an Ad Hoc Workgroup, the Research Subcommittee determined to continue this discussion at its next in-person meeting. Subcommittee members requested AMA staff to provide information on types of survey questions for the Subcommittee to consider in a future staff note for that meeting.

- **Extant Database Proposal Review and General Discussion**
  AMA RUC staff sent out a solicitation to specialty societies to see if any societies were interested in submitting a database/registry for considered to be a RUC-approved extant database for the January RUC meeting. The Subcommittee received two proposals from the American College of Cardiology for the "American College of Cardiology's LAAO Registry™" and the "EP Device Implant Registry™". The Subcommittee inquired whether the procedure start time and procedure stop time fields in the registry data collection forms align with RUC intra-service or skin-to-skin

time, and the ACC presenter noted that the form does not have a procedure time definition that fully aligns with the RUC's definition for surgical procedure intra-service time. Subcommittee members also inquired about the auditing process and the ACC presenter noted that they have an internal auditing and quality assurance process when ingesting the submitted data into their registries. It was also asked whether registry data could always be mapped to individual CPT codes. The presenter noted that when multiple procedures are performed during the same encounter, it was not currently possible to split out what portion of the procedure time tied to each CPT code. The Subcommittee noted that, although the registries have these attributes, these challenges were not unique to these registries and were present in previously approved extant databases and overall both databases met the RUC's requirements. **The Research Subcommittee approved the American College of Cardiology's LAAO Registry™ and the EP Device Implant Registry™ as Extant Database sources.** AMA Staff noted that the attributes and potential shortcomings of this dataset will be recorded in the Annotated List of RUC Actions document that has been maintained since the inception of the RUC.

The RUC approved the Research Subcommittee Report.

XII. Practice Expense Subcommittee (Tab 15)

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

At the January 2024 RUC meeting, the PE Subcommittee considered Tab 10 Genetic Counseling Services. **The PE Subcommittee recommended the creation of three new clinical staff activity codes as follows:**

- **Pre-service period:** *Collect/Update personal and family history/pedigree*
  Collecting a genetic personal and family history is a distinct clinical activity from typical family history collection performed by other specialists. Multiple societies including the American College of Medical Genetics, National Society of Genetic Counselors, and the National Comprehensive Cancer Network have recommendations that include typical family history collection for genetic evaluation extending to 2nd & 3rd-degree relatives (aunts/uncles, cousins, great aunts/uncles, etc.) which is not common practice amongst non-genetics specialties. Additionally, family history collection performed via pedigree is more detailed, as it involves collection and analysis per-relative instead of per-condition. History collection this way is known to increase the identification of appropriate patients for genetic testing, however, it is time intensive compared to the typical family history taken for non-genetics specialties.

- **Post-service period:** *Review Genetic/Follow Up Test Results*
  This new clinical activity includes review of genetic and other follow-up test results received after the date of service. Genetic test results typically identify one or more variants, which require further evaluation by the genetic counselor. This includes researching and assessing these findings in clinical databases (e.g. ClinVar, ClinGen, gnomAD) prior to communicating results to the patient, family, and medical team. This review determines the presence or absence of prior reports of the identified variant(s), and when present, also includes the associated classification of such variant(s) as these classifications may vary between laboratories. Critically, this review includes comparison to any other interpretations of identified variant(s) that may differ from that of the patient's report and/or have been previously provided to the patient's family. Variant interpretation and classification directly impact clinical management.

- **Post-service period:** *Correspondence Regarding Genetic/Follow Up Test Results*

This new clinical activity was created to help clarify that this type of correspondence and documentation is specifically related to that which occurs after genetic testing and other results are completed, received, and reviewed in the post-service period. This includes medical documentation, communicating the results to the healthcare team, and writing patient/family letters to facilitate communication of results amongst at-risk family members. Genetic counseling documentation is noted to be particularly detailed given the comprehensive review occurring in the new clinical activity described above and therefore, requires significant time.

The PE Subcommittee considered Tab 5 Bladder Neck and Prostate Procedures and Tab 7 Percutaneous Radiofrequency Ablation of Thyroid which both contain new high-cost supply items. The PE Subcommittee expressed its continued concern with the issue of high-cost supplies and the outsized impact these items have within the current practice expense RVU methodology. **The RUC will continue to call on CMS to separately identify and pay for high-cost disposable supplies (i.e., priced more than $500) using appropriate HCPCS codes.**

In addition, the PE Subcommittee recommended, and the RUC agreed, with the following addition to the PE SOR:

If there is a different patient population in the non-facility setting, a vignette should be provided for the non-facility setting in the PE SOR.

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 16)

Matthew Grierson, MD, Chair of the Relativity Assessment Workgroup provided the report to the RUC.

Review Action Plans

The Workgroup reviewed two action plans, one for Electroretinography (92273, 92274, 0509T) in which the specialty societies indicated and the Workgroup agreed about concerns of possible misreporting. **Therefore, the Relativity Assessment Workgroup recommended referral to CPT Assistant to create an article to address proper reporting of CPT 92273, 92274, and 0506T, accompanied by AAO and AOA educational outreach to providers. In addition, the specialty societies encourage the MACs to develop LCDs and LCAs for these services. The RAW will review after publication of the CPT Assistant article.**

The second action plan reviewed was for Hyperbaric Oxygen Under Pressure (99183, G0277). The Workgroup noted that in January 2023, the RUC recommended 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. However, in September 2023, the specialties indicated they did not intend to submit a CPT code change application (CCA). Therefore, this issue was placed on the January 2024 Relativity Assessment Workgroup agenda to address. In January 2024, the specialty societies indicated that they believe the current separate coding of the G code and the CPT code are clear and work appropriately. **The Workgroup disagreed and indicated that one clear and consistent coding structure should exist and the specialty society should submit a CPT code change application. The specialties should revise 99183 to be time-based well as modified to appropriately describe the treatment delivery, attendance and supervision or develop a coding change creating a practice expense only code to capture the service appropriately and eliminate the need for G0277.**

Practice Expense Screen
The Workgroup recommended lowering the threshold for the Stand-Alone PE Procedure Time screen Medicare allowed charges from $100,000 to $50,000 for codes that have 0.00 work RVUs, including direct equipment inputs that total in direct expense to the individual code to $100 or more, and have PE procedure times (CA021) greater than five minutes.

The Relativity Assessment Workgroup reviewed the services identified via this screen at the January 2024 meeting and noted that 77372 and 77373 appeared on the first CMS iteration of this screen and were validated in April 2013. Additionally, the radiation treatment delivery codes identified (G6004-G6016) are currently referred to the CPT May 2024 meeting for revision, therefore the stand alone PE procedure time will be reviewed when these services go through the RUC process. **Lastly, codes 93229 and 93271 were identified and the Workgroup requests an action plan for April 2024, on how to best address these services.**

XIV. Multi-Specialty Points of Comparison Workgroup (Tab 17)

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

Review of the Service to Sunset off MPC List and Specialty Code Recommendations
The MPC Workgroup members reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list. Participating specialty societies used a submission form requested during Other Business at the January 2023 MPC Workgroup meeting to complete their code recommendations. This submission form includes a checklist of the applicable absolute and suggested criteria and a comment box for a more granular rationale for each code submission. Representatives from specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members noted that specialty societies should be encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list. The MPC Workgroup reminded the specialty societies that any specialty with 10% or more utilization of the code should comment on the appropriateness of addition or deletion of a code.

The MPC Workgroup members agreed to maintain 3 codes, delete 11 codes, and add 7 codes to the MPC list with justification provided by specialty societies in their recommendations.

Review of Services to Sunset – Recommendation to Maintain Codes on MPC List
In June 2021, the MPC Workgroup recommended identifying and reviewing codes on the MPC list that have not been reviewed in the last 15 years as part of its annual review. There were 14 services on the MPC list that have not been RUC reviewed in the last 15 or more years. These codes have been reviewed by the specialties, and they have submitted their recommendations to either “maintain” or “delete” these services, along with their supporting rationale.

The American Academy of Audiology recommended to maintain three services, 92567, 92568 and 92604, on the MPC list, to which the MPC Workgroup agreed. These services will be flagged for review next year per the 15+ year sunset screen.

The American College of Radiology, Outpatient Endovascular and Interventional Society and Society of Interventional Radiology submitted a recommendation to maintain two services, 49440 and 50593, on the MPC list. The MPC Workgroup disagreed with the submission to maintain these services on

the MPC list and recognized that both services were valued based on a building block methodology and not supported by survey.

The remaining 9 services (33207, 46600, 51797, 92002, 92004, 92012, 92014, 99406 and 99407) set to sunset off the MPC list did not receive any specialty society response to maintain, thus the Workgroup agreed to delete them from the MPC list.

The MPC Workgroups recommends maintaining the following 3 services: 92567, 92586 and 92604. The MPC Workgroups recommends deleting the following 11 services: 33207, 46600, 49440, 50593, 51797, 92002, 92004, 92012, 92014, 99406 and 99407.

MPC List Services Additions

The MPC Workgroup annually solicits the specialty societies for codes that should be added to or deleted from the MPC list. There were 8 services recommended for addition to the MPC list by four participating specialty societies**.**

The American College of Chest Physicians and American Thoracic Society recommended adding code 94010 to the MPC list, to which the MPC Workgroup agreed. The American Society of Regional Anesthesia and Pain Medicine recommended addition of four services, 27096, 64415, 62324 and 64625, to the MPC list. The MPC Workgroup agreed with the addition of 64415, 62324 and 64625 but disagreed with adding 27096. The Workgroup noted that 27096 was valued by crosswalk and is not survey supported, but unlike 64625, the service does not fill a work RVU gap on the MPC list and thus does not enhance the MPC list. The American Academy of Ophthalmology recommended addition of three services, 67914, 67917 and 67036, to the MPC list, to which the MPC Workgroup agreed.

The MPC Workgroup recommends adding the following 7 services to the MPC List: 62324, 62325, 64415, 67036, 67914, 67917 and 94010. The MPC Workgroup does not recommend adding 27096 to the MPC List.

Other Business

The Workgroup noted that the submission form specialties used for submitting changes to the MPC list helped facilitate review of the MPC list. AMA staff will solicit feedback from the specialty societies prior to the next meeting for further refinement.

The Workgroup discussed future review of the Suggested Criteria listed in the MPC Summary of Process. It was suggested that developing a hierarchy to more effectively address any potential gaps in the criteria would be beneficial to the review process. An example would be when to include a code on the MPC list that was valued by a crosswalk and not by survey: a proposed code for addition to the MPC list that was valued by crosswalk may be appropriate to add if it fills a work RVU gap on the MPC list. Future discussion of this topic will occur after the specialty societies are solicited for further review of the submission form and their feedback is compiled by AMA staff.

The Workgroup Chair recommended another addition to the Suggested Criteria wherein codes that were surveyed within the last 10 years are preferred and given preference over those that were surveyed more than 10 years ago. It was noted in discussion that this suggested criterion may prevent less turnover on the MPC list with respect to the 15-year or more sunset review and prioritize including more recent codes.

XV. HCPAC Review Board (Tab 18)

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

The HCPAC Review Board reviewed the addition of CPT codes 96113 *Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)* and 96202 *Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians /caregivers; initial 60 minutes* to the HCPAC Multi-Specialty Points of Comparison (MPC) list. **After review of the criteria, the HCPAC voted to accept the addition of CPT code 96113 to the HCPAC MPC list.**

The HCPAC Review Board reviewed the following Relative Value Recommendations for CPT 2025:

Physical Medicine & Rehabilitation (PE Only) (Tab 18)
Brooke Bisbee, DPM, Randy Boldt, APTA, Angela Pennisi, PT, DPT, Susan Walsh, DPM, Mary Walsh-Sterup, OTR/L

In February 2017, the RUC HCPAC Review Board submitted recommendations for 19 Physical Medicine and Rehabilitation codes. At the time, the RUC HCPAC considered the typical number of services reported per session, which was 3.5 units based on CMS data, to ensure there was no duplication in the standard inputs for pre and post time. Based on 2022 Medicare data, a mean value of 3.5 codes are reported per session, which is consistent with the 2017 review, and was used to re-review the RUC HCPAC recommendations for this code family. Therefore, the RUC placed the nominated therapy codes on the CMS / Relativity Assessment Workgroup level of interest to review the practice expense inputs at the January 2024 RUC HCPAC meeting.

Compelling Evidence
In the Notice of Proposed Rulemaking for 2024, CMS received public nominations on 19 therapy codes as potentially misvalued. An interested party asserted that the direct PE clinical labor minutes, as recommended by RUC HCPAC, reflected inappropriate multiple procedure payment reductions (MPPR), which are duplicative of the CMS MPPR policy implemented in CMS' claims processing systems. CMS reviewed the clinical labor time entries for these 19 therapy codes noting that they did not believe a payment reduction should have been applied in some instances to the 19 nominated therapy codes' clinical labor time entries since the payment valuation reduction would be duplicative of the MPPR applied during claims processing. CMS indicated that the valuation of these services would benefit from additional review through the AMA RUC HCPAC valuation process. **The Practice Expense Subcommittee and HCPAC Review Board accepted compelling evidence that incorrect assumptions may have been made during the previous valuation of these services.**

Modalities
For each modality service, the PT/OT Aide greets the patient, provides and, if needed assists with appropriate gowning, and draping for the performance of the procedure. The Aide procures and sets up any necessary space, equipment, and supplies for the procedure. Further, the Aide will prepare and position the patient in preparation for the procedure and provide any additional physical assistance. During the procedure, the Aide will assist the Therapist with supplies and at the end of the procedure the Aide will clean all equipment and dispose of supplies. The modality services CPT codes are

always reported with other services that also include clinical labor time for several of the same clinical activities. Therefore, the PE Subcommittee and the HCPAC accounted for the typical number of codes reported on a claim and the impact of the therapy MPPR on applicable clinical activities as follows.

Supervised (97012-97022, G0283)

For the following inputs, the professional organizations and HCPAC agreed that 1.33 minutes is appropriate:

- CA009 *Greet patient, provide gowning, ensure appropriate medical records are available*
- CA013 *Prepare room, equipment and supplies*
- CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*
- CA024 *Clean room/equipment by clinical staff*

CA010 and CA035 are not applicable to the supervised modalities.

Further, in this circumstance, the MPPR would be applied to avoid overlapping minutes but ensure correct valuation depending on a given session scenario where the typical 3.5 codes are reported. To account for the MPPR, it was determined that 3.5 codes are billed per session and the first is paid at 100% and the second and subsequent units get paid at half and so forth for practice expense (eg, 1.00+0.5+0.5+0.25 = 2.25). For example, since the standard of clinical staff time for greeting the patient, etc. is 3 minutes, it would be appropriate to take the 3 minutes and divide it by 2.25 which would equal 1.33. Therefore, 1.33+0.67+0.67+0.34 = 3 minutes. Further, for the three most common therapy sessions, shown in the table below, the total number of minutes for clinical staff activities, such as greet the patient, would be approximately 3 minutes for CPT codes 97012, 97014/G0283, 97016, 97018, and 97022 when billed with a therapy code. However, for CPT code 97022, the professional organizations and HCPAC agreed that 8 minutes is necessary to clean the entirety of the whirlpool after each patient use.

% of Medicare Claims (CY 2022)	1	2	3	4	Number of CPT/HCPCS Codes on Claim
10%	97110	97110	97140		3
8%	97110	97110	97112	97140	4
8%	97110	97110	97112	97530	4

**Please see the full table in the attachments labeled Appendix A.*

The professional organizations and HCPAC agreed that the 2 minutes for the PT Aide for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%)* instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97012, 97014/G0283, 97016, 97018, and 97022.

The professional organizations and HCPAC agreed on the existing medical supplies for CPT codes 97012, 97014/G0283, 97016, 97018, and 97022. However, the equipment inputs for each supervised modality code were revised by the HCPAC to be consistent with the intra-service time or the default formula, whichever was higher, to appropriately account for the actual time utilizing the given equipment. For the modalities, the HCPAC determined that in some instances the default formula did not provide enough equipment minutes to ensure the totality of the time the patient spends using the equipment when typically, only 1 modality is reported in a session and there is no overlap in use of the equipment for these services. However, for CPT code 97022, the professional organizations and HCPAC agreed that the equipment minutes should reflect the intra-service time and cleaning time, totaling 20 minutes, since the whirlpool is in use by a single patient for the service and while clinical staff sanitize and clean the whirlpool after use.

The HCPAC recommends the direct practice expense inputs for CPT codes 97012, 97014, 97016, 97018, 97022 and HCPCS code G0283 as modified by the Practice Expense Subcommittee and HCPAC.

Constant Attendance (97032-97035)

For the following inputs, the professional organizations and HCPAC agreed that 1.33 minutes is appropriate:

- CA009 *Greet patient, provide gowning, ensure appropriate medical records are available*
- CA013 *Prepare room, equipment and supplies*
- CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*
- CA024 *Clean room/equipment by clinical staff*

CA010 and CA035 are not applicable to the constant attendance modalities.

To account for the MPPR, and given that 3.5 codes are typically billed per session, 1.33 minutes is appropriate for CPT codes 97032, 97033, 97034, and 97035 when billed in any given session. For example, since the standard of clinical staff time for greeting the patient, etc. is 3 minutes, it would be appropriate to take the 3 minutes and divide it by 2.25 which would equal 1.33. Therefore, 1.33+0.67+0.67+0.34 = 3 minutes.

For CA029 *Check dressings, catheters, wounds* the professional organizations and HCPAC agreed that 1 minute is appropriate for CPT codes 97033 and 97035 which is consistent with the current and standard input and necessary to assess the integrity of the skin.

The professional organizations and HCPAC agreed on the existing medical supplies for CPT codes 97032, 97033, 97034, and 97035. However, the equipment inputs for each constant attendance modality code were revised by the HCPAC to be consistent with the intra-service time or the default formula, whichever was higher, to appropriately account for the actual time utilizing the given equipment. For the modalities, the HCPAC determined that in some instances the default formula did not provide enough equipment minutes to ensure the totality of the time the patient spends using the equipment when typically, only 1 modality is reported in a session and there is no overlap in use of the equipment for these services.

The HCPAC recommends the direct practice expense inputs for CPT codes 97032, 97033, 97034, and 97035 as modified by the Practice Expense Subcommittee and HCPAC.

Therapeutic Procedures (97110-97140) & Activities of Daily Living (ADL) (97530-97542)

During the Therapeutic Procedures, the PT/OT Assistant often assists the clinician with obtaining and recording measures. This may include recording performance data, physical facilitation with the patient, grading challenges in environment, and other clinical assistance throughout the session. An Assistant provides the clinically appropriate support for the patient as the therapist facilitates the performance in therapeutic exercise, neuromuscular re-education, gait training, aquatic therapy, manual therapy, therapeutic activities, and wheelchair management. The PT/OT Aide assists with re-positioning the patient, adjusting equipment throughout the procedure, cleaning equipment and surfaces as well as providing physical assistance as needed. The PE Subcommittee and the HCPAC accounted for the typical number of codes reported on a claim and the impact of the therapy MPPR on applicable clinical activities as follows.

For the following inputs, the professional organizations and HCPAC agreed that 1.33 minutes is appropriate:

- CA009 *Greet patient, provide gowning, ensure appropriate medical records are available*
- CA010 *Obtain vital signs*
- CA013 *Prepare room, equipment and supplies*
- CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*
- CA024 *Clean room/equipment by clinical staff*
- CA035 *Review home care instructions, coordinate visits/prescriptions*

To account for the MPPR, and given that 3.5 codes are billed per session, 1.33 minutes is appropriate for CPT codes CPT codes 97110, 97112, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 when billed in any given session. For example, since the standard of clinical staff time for greeting the patient, etc. is 3 minutes, it would be appropriate to take the 3 minutes and divide it by 2.25 which would equal 1.33. Therefore, 1.33+0.67+0.67+0.34 = 3 minutes. Further, for CA010 the professional organizations stated that it is typical for 1-3 vital signs to be recorded during a single therapeutic service.

For CPT code 97113, which is typically reported on the claim with a median of 3 units and not typically reported with other therapy or modality codes, it was determined that 1.5 minutes was appropriate for CA009, CA010, CA016, and CA035 to conduct aquatic therapy. Further, it was determined that 4 minutes is appropriate for CA013 to appropriately prepare the aquatic therapy pool and aquatic exercise kit and 6 minutes for CA024 to clean the aquatic therapy pool and aquatic exercise kit, respectively. For CA018 *Assist physician or other qualified healthcare professional—directly related to physician work time (100%)* 15 minutes is necessary as there must always be two individuals in the pool with the patient for the entire procedure for CPT code 97113.

The professional organizations and HCPAC agreed that 2.5 minutes for the PT Assistant and 5 minutes for the PT Aide for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%*) instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97110, 97112, 97116, and 97140. For CPT code 97113, 2 minutes of for the PT Aide for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%*) instead of CA021 *Perform procedure/service—NOT directly related to physician work time* for both the PT Aide and PT Assistant.

The professional organizations and HCPAC agreed that 3.75 minutes for the PT Assistant and for the PT Aide, respectively, for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%*) instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97530 and 97542. Further, 7.5

minutes for the PT Assistant for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%)* instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97533, 97535, and 97537.

For CA029 *Check dressings, catheters, wounds* the professional organizations and HCPAC agreed that 1 minute is appropriate for CPT codes 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 which is consistent with the standard input. This is a reduction based on the current input of 1.5 minutes. Further, the recommended 1 minute is justified given that this time is spent checking the integrity of the skin for each separate procedure performed.

CA033 *Perform regulatory mandated quality assurance activity (service period)* is no longer standard practice for CPT code 97113 and therefore the recommendation of 0 minutes is appropriate.

The professional organizations and HCPAC agreed on the existing medical supply inputs for CPT codes 97113, 97140, 97530, 97533, 97535, 97537, and 97542. However, for CPT codes 97110, 97112, and 97116, it was agreed that 0.9 was appropriate for SJ056 *Thera-bands (6in width)* instead of the existing input. This is because 20 ft of Thera-bands are provided during a normal 10 visit treatment plan, which would equate to a proxy of 2 ft provided per visit. Therefore, 0.9 is appropriate to account for the MPPR reduction (0.9 + 0.45 + 0.45 + 0.225 = ~2).

For CPT codes 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 the equipment inputs were confirmed by the HCPAC to be consistent with the default formula to appropriately account for the actual time utilizing the given equipment.

The HCPAC recommends direct practice expense inputs for CPT codes 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 as modified by the Practice Expense Subcommittee and HCPAC.

The RUC filed the HCPAC report as presented.

XVI. Rotating Seat Elections (Tab 19)

Administrative Subcommittee
James Waldorf, MD informed the RUC that the Administrative Subcommittee communicated over email on November 27, 2023.

Review Rotating Seat Election Rules and Candidates Nominated (Tab 19)
The Administrative Subcommittee reviewed and approved the nominations for the internal medicine and primary care rotating seats as well as reviewed the rotating seat policies and election rules. The Subcommittee noted that because there are three candidates for the internal medicine rotating seat there may be two ballots, ranking the top 3 until one candidate obtains a majority vote, as delineated by the RUC Rotating Seat Policies and Election Rules.

The Administrative Subcommittee reviewed the nomination for the primary care rotating seat, Jennifer Aloff, MD, American College of Physicians, and determined that she meets the primary care rotating seat qualifications. The Subcommittee noted that since there is only one nominee for the primary care rotating seat "an election will be unnecessary in the case that there is an unchallenged seat, and the seat will be awarded to the candidate by voice vote."

The RUC approved the Administrative Subcommittee report as provided.

The elections occurred Friday, January 19, 2024.

Robert Zipper, MD, Society of Hospital Medicine (SHM), was elected to the RUC's Internal Medicine rotating seat.

Jennifer Aloff, MD, American Academy of Family Physicians (AAFP), was elected to the RUC's Primary Care rotating seat.

The term for these rotating seats is two years, beginning in March 2024 and ending in February 2026 with the provision of final recommendations to CMS.

XVII. New/Other Business (Tab 20)

- A RUC member requested additional Medicare and Medicaid data, in particular data on Medicare Advantage, which is growing among Medicare beneficiaries. AMA staff stated that the AMA is actively working with CMS on updated Medicaid data including Medicare Advantage data. AMA staff also clarified that the 5% Medicare sample informs the demographic information given warranted patient privacy concerns. The utilization data that is used to inform RUC recommendations is based on 100% traditional Medicare claims. The ICD-10-CM and billed together data are sourced from the 5% file as well, though are only displayed if they exceed a minimum threshold to ensure the sample is representative and to comply with CMS data privacy requirements.

- A RUC member inquired about new CPT codes that are flagged as new technology and come up for re-review but have low utilization and if the specialties are required to re-survey or if they may opt to maintain the current value. The RUC Relativity Assessment Workgroup (RAW) Chair responded that the codes are handled on a case-by-case basis on what determines re-survey, although, when Specialties submit an action plan, they can make an argument for why the value should be maintained. A RUC member suggested that the RAW consider a screen to re-review codes where the median performance rate, captured in the initial survey process, is low utilization. Another member suggested that codes with high-cost disposable supplies be flagged for PE re-review. **These two suggestions were referred to the RAW for further discussion.**

- A RUC member inquired about the current mechanisms for liaising between the CPT Editorial Panel and RUC. Several members and AMA staff clarified that CPT Editorial Panel members are appointed by the AMA Board of Trustees. CPT leadership appoints the CPT Editorial Panel Representative to the RUC. The individual in this position, along with AMA staff, provides coding guidance and intent at RUC meetings and communicates RUC referrals and valuation issues to the Panel. The RUC also offers an opportunity for RUC members to attend CPT meetings to observe the process and support the CPT Editorial Panel RUC Representative on RUC related issues at the CPT Editorial Panel meeting and when the issues come to the RUC for valuation. AMA CPT staff and AMA RUC staff attend both the CPT and RUC meetings to support the CPT Editorial Panel and RUC as liaisons. **This inquiry prompted the creation of updated process documents outlining the responsibilities of the RUC Observer to the CPT Editorial Panel, review of the CPT Editorial Panel RUC Representative responsibilities, and additional resources for RUC members regarding the CPT Editorial Panel processes. These documents shall be distributed during orientation and available on the RUC Collaboration website for reference as needed. Further, all RUC members are encouraged to take the opportunity to volunteer to observe a CPT meeting and/or listen to the CPT proceedings virtually, if possible.**

- A RUC member inquired about the process following the submission of a level II (comment only) level of interest (LOI). More specifically, when no formal comments are submitted as level II participant, is the RUC member allowed to speak to the recommendations of presenters (level I participants). The RUC Chair responded that the specialty society may submit written comments for consideration and further, the specialty society advisor is welcome to speak to issues via the microphones set up around the room should they wish to contribute additional information to the discussion.

The RUC adjourned at 11:24 AM PT on Saturday, January 20, 2024.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE **Tab 14**
Research Subcommittee Report
Thursday, January 18th

Members Present: Margie Andreae, MD (Chair), Jeffrey Paul Edelstein, MD (Vice Chair), Anita Arnold, DO, Leisha Eiten, AuD, CCC-A, John Heiner, MD, Omar Hussain, DO, Kristopher Kimmell, MD, M. Douglas Leahy, MD, Swati Mehrotra, MD, Anne Miller, MD, Matthew Sideman, MD, Mark Villa, MD, David Yankura, MD, Robert Zipper, MD, Robert Zwolak, MD

I. Minutes, October 10 Research Subcommittee Specialty Requests Meeting Report Review

The Research Subcommittee report from the October 10th conference call included in Tab 14 of the January 2024 agenda materials was approved without modification.

II. Site-of-Service RUC Survey Question

During the January 2023 RUC New Business discussion, 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 respondent performs 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 *(this editorial change has already been made by AMA RUC staff).* 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. The RUC referred this topic to the Research Subcommittee.

At the April 2023 Research Subcommittee meeting, the Subcommittee members expressed broad support for retaining the site-of-service questions in general, and that it might be beneficial to have the survey respondent estimate percentages for hospital, ASC and office. Subcommittee members noted that changes to the first site of service question would impact the subsequent discharge question and same-day visit question. Finally, the Subcommittee discussed whether the standard 000-day global survey template should also include site-of-service questions. There was broad support for this change in general. The discussion of this topic continued through the January 2024 Research Subcommittee meeting.

For the January 2024 meeting, the Chair and AMA RUC staff prepared two separate options for the Research Subcommittee's consideration. The first option instructed respondents to estimate the percentage of time they perform the service in the office, ASC and hospital settings. The second option was similar to the existing site of service questions, with the addition of asking the respondent to answer the questions based on the patient described in the survey vignette. Research Subcommittee members observed that the standard survey questions related to physician work and time direct the respondent to base their answers on the patient in the vignette, and the proposed change in the second option would align with these other questions. It was also observed that this change would allow the RUC to review the data based on the typical patient (assuming the patient in the vignette is typical). The site of service questions currently direct the respondent to base their answers on their typical experience which may not necessarily match the patient in the vignette.

The Research Subcommittee approved for the site of service questions and summary of recommendation (SOR) form to use the following text for the 000-day, 010-day and 090-day standard RUC survey instruments:

Question 2c) Post-Operative Work

Please respond to the following questions for the survey code(s) based on the typical patient described in the vignette(s) below.

[codes, descriptors, vignettes and globals displayed]

Where do you perform this procedure for the typical patient?

- **Typically performed at a hospital**
- **Typically performed in an ASC**
- **Typically performed in an office**

[Displayed for those that selected hospital:]

When do you discharge the patient?

- **The same day as the procedure**
- **After an overnight stay-less than 24 hours**
- **After an overnight stay-more than 24 hours**

[Displayed for those that selected overnight stay:]

After the patient is transferred from the recovery room, do you or a qualified healthcare professional evaluate and examine the typical patient on the floor or other hospital unit later on the same day? Yes/No

Corresponding Changes to RUC Summary of Recommendations (SOR) form:

Site of Service (Complete for 000, 010 and 090 Globals Only)
Percent of survey respondents who stated they perform the procedure for the typical patient; In the hospital 0% , In the ASC 0%, In the office 0%

Of those survey respondents that stated they perform this procedure for the typical patient in the hospital, the percent of respondents who stated the patient is discharged: The same day 0%, Overnight stay-less than 24 hours 0)%, Overnight stay-more than 24 hours 0%

Of those survey respondents that keep the typical patient overnight, __ percent stated they perform an E&M service later on the same day

III. Discussion – Physician Work Intensity

During the RUC's *New Business* discussion at the April 2023 RUC meeting, a RUC member inquired about the value of intensity and how that impacts the adjudication of services. With continuing advancements in technology, the inquiring member, and other RUC members, were aligned that the use of evolving technology, which may lead to a decrease in time, does not necessarily equate to less intensity and/or complexity of a procedure. As a result of the discussion, another RUC member requested that the Research Subcommittee review the intensity and complexity questions on the RUC survey to better reflect how intense/complex a given procedure is relative to other procedures in the MFS. The request was referred to the Research Subcommittee for discussion. Minutes from the Research Subcommittee's

most recent review and discussion of the survey intensity and complexity question were provided in the agenda materials, as well as the current standard intensity and complexity questions**.**

The Subcommittee discussed the current intensity and complexity questions in the survey instrument briefly. During the discussion, AMA RUC staff noted that the background definitions for time, mental effort and judgement, technical skill, physical effort and psychological stress came from the Centers for Medicare & Medicaid Services (CMS) and could only be changed by CMS via rulemaking. Some Subcommittee members suggested the creation of an Ad Hoc Workgroup to explore the survey intensity and complexity questions. The Chair noted that this topic was most recently considered by the Subcommittee in January 2021 and at that time, the Subcommittee decided that no changes were necessary at that time. Instead of forming an Ad Hoc Workgroup, the Research Subcommittee determined to continue this discussion at its next in-person meeting. Subcommittee members requested for AMA staff to provide information on types of survey questions for the Subcommittee to consider in a future staff note for that meeting.

IV. Extant Database Proposal Review and General Discussion

AMA RUC staff sent out a solicitation to specialty societies to see if any societies were interested in submitting a database/registry for considered to be a RUC-approved extant database for the January RUC meeting. The Subcommittee received two proposals from the American College of Cardiology for the "American College of Cardiology's LAAO Registry™" and the "EP Device Implant Registry™". The Subcommittee inquired whether the procedure start time and procedure stop time fields in the registry data collection forms align with RUC intra-service or skin-to-skin time, and the ACC presenter noted that the form does not have a procedure time definition that fully aligns with the RUC's definition for surgical procedure intra-service time. Subcommittee members also inquired about the auditing process and the ACC presenter noted that they have an internal auditing and quality assurance process when ingesting the submitted data into their registries. It was also asked whether registry data could always be mapped to individual CPT codes. The presenter noted that when multiple procedures are performed during the same encounter, it was not currently possible to split out what portion of the procedure time tied to each CPT code. The Subcommittee noted that, although the registries have these attributes, that these challenges were not unique to these registries and were present in previously approved extant databases and overall both databases met the RUC's requirements. **The Research Subcommittee approved the American College of Cardiology's LAAO Registry™ and the EP Device Implant Registry™ as Extant Database sources.** AMA Staff noted that the attributes and potential shortcomings of this dataset will be recorded in the Annotated List of RUC Actions document that has been maintained since the inception of the RUC.

AMA/Specialty Society RVS Update Committee **Tab 15**
Practice Expense Subcommittee
January 17, 2024

Members Present: Scott Manaker, MD, PhD, (Chair), Amy Aronsky, DO, Gregory Barkley, MD, John Blebea, MD, Michael Booker, MD, Joseph Cleveland, MD, Neal Cohen, MD, William Gee, MD, David Han, MD, Katie Jordan, OTD, OTR/L, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, MBA, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, Thomas Weida, MD, Adam Weinstein, MD, and Lawrence Simon, MD (CPT Resource)

I. New/Other Business

There was limited time for a new business discussion. Doctor Manaker provided the following suggestion to present to the RUC:

> **If there is a different patient population in the non-facility setting, a vignette should be provided for the non-facility setting in the PE SOR.**

The issue of High-Cost Supplies remains a concern for the PE Subcommittee. The RUC will continue to include our policy on this issue in its cover letters to CMS. **AMA Staff will provide an updated spreadsheet for high-cost supplies over $500 and over $1000 for the April PE meeting.**

Finally, a member suggested that it would be helpful to include the contents of the packs/trays/kits in the body of the PE spreadsheet when they are recommended as supply items. This will be taken under advisement as content tabs are already included separately in the PE Spreadsheet.

II. Practice Expense Recommendations for CPT 2025

The table below corresponds to the final PE spreadsheets as adopted at the meeting and should be referred to for the details on the practice expense input recommendations for each tab.

Tab	Title	PE Input Changes	Consent Calendar
4	Skin Cell Suspension Autograft	Modifications	
5	Bladder Neck and Prostate Procedures	Modifications	
6	Guided High Intensity Focused Ultrasound	No Changes	
7	Percutaneous Radiofrequency Ablation of Thyroid	Modifications	
8	Fascial Plane Blocks	Modifications	

Tab	Title	PE Input Changes	Consent Calendar
9	Magnetic Resonance Examination Safety Procedures	Modification	
10	Genetic Counseling Services (PE Only)	Modifications	
11	Therapeutic Apheresis and Photopheresis (PE Only)	No Changes	
12	Insertion of Tunneled Centrally Inserted Central Venous Catheter	Referral to CPT Editorial Panel	X
13	Insertion of Cervical Dilator	Modification	
18	Physical Medicine & Rehabilitation (PE Only)	Modifications	

Members: Doctors Matthew Grierson (Chair), Gregory DeMeo (Vice Chair), Jennifer Aloff, Amr Abouleish, Elizabeth Blanchard, Dale Blasier, Audrey Chun, Patrick Godbey, Martha Gray, Gregory Harris, John Proctor, Kyle Richards, Karen Smith, RD, Michael Sutherland, John Thompson and Korinne Van Keuren, DNP.

I. Review Action Plans

Electroretinography (92273, 92274, 0509T)

In 2015, CPT code 92275 *Electroretinography with interpretation and report* was identified via the CMS High Expenditure screen. In January 2016, the specialty society noted that they became aware of inappropriate use of CPT code 92275 for a less intensive version of this test for diagnosis and indications that are not clinically proven and for which less expensive and less intensive tests already exist. The utilization of CPT code 92275 was appropriately low until 2013 when it suddenly increased by 300%. CPT changes were necessary to ensure that the service for which 92275 was intended was clearly described as well as an accurate vignette and work descriptor were developed. The RUC recommended CPT code 92275 be referred to the CPT Editorial Panel. In September 2017, the CPT Editorial Panel replaced electroretinography code 92275 with two new codes to describe electroretinography full field and multi focal. A category III code was retained for pattern electroretinography. In January 2018, the RUC reviewed these services and recommended lower work RVUs for the two new codes than code 92275 that was deleted. CMS also assigned a work RVU to code 0509T. In October 2020, the RUC identified one code family, Electroretinography (CPT codes 92273, 92274 and 0509T) that were reviewed in April 2017, October 2017 and January 2018 and have increased more than 10% in work RVUs from what was projected. In reviewing the utilization assumptions and 2019e Medicare utilization, there was a 38% increase in work RVUs. Since both the source volume from deleted code 92275 and the new volume for the three new codes all have assigned RVUs and are Medicare status A, it is a like comparison between previous reporting and current reporting (unlike when category III codes are not assigned an RVU). In January 2021, the RUC recommended that codes 92273, 92274 and 0509T be reviewed in 3 years (January 2024) to review utilization. Despite no work neutrality issues, the Workgroup still had concerns about the volume growth and the unexpected distribution among the three new codes.

In January 2024, the Workgroup reviewed the action plan in which the specialty societies note that the increased claims volume is explained by expansion of the use of ffERG (CPT 92273) in disorders other than retinal dystrophies, along with a decrease in 0509T claims. Only 4% of 2021 claims for CPT 92273 were associated with diagnoses consistent with retinal dystrophies, while 31% were associated with a diagnosis of macular degeneration, 20% with optic nerve disorders, 13% with glaucoma, and 13% with diabetes. Although ffERG changes have been described in patients with these disorders, the test is not widely considered to be clinically useful in their management. Published data suggest it is still in development or used as a research tool for the study of macular degeneration, diabetic retinopathy, and glaucoma. Additionally, only two Medicare Administrator Contractors (MACs) cover electroretinography (ERG), but it depends on the diagnosis and what is being treated. Lastly, use of pattern ERG (0506T) for diagnosis and management of glaucoma has some support in the literature, but it has not been widely adopted considering the prevalence of the disease. Likewise, Medicare utilization continues to decrease.

The Workgroup discussed how best to address this issue, noting that an immediate resurvey would not address the incorrect reporting of these services. **The Relativity Assessment Workgroup recommends referral to CPT Assistant to create an article to address proper reporting of CPT 92273, 92274, and 0506T, accompanied by AAO and AOA educational outreach to providers. In addition, the specialty societies encourage the MACs to develop LCDs and LCAs for these services. The RAW will review after publication of the CPT Assistant article.**

Hyperbaric Oxygen Under Pressure (99183, G0277)

In April 2022, the Relativity Assessment Workgroup identified code G0277 via the high volume growth screen with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020. The Workgroup requested that the specialty societies submit an action plan for September 2022. In September 2022, the RUC recommended that the review of PE at January 2023 RUC Meeting. In January 2023, 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 recommended 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.

In September 2023, the specialties indicated they did not intend to submit a CPT code change application (CCA). Therefore, this issue was placed on the January 2024 Relativity Assessment Workgroup agenda to address.

In January 2024, the specialty societies indicated that they believe the current separate coding of the G code and the CPT code are clear and work appropriately. **The Workgroup indicated that one clear and consistent coding structure should exist and the specialty society should submit a CPT code change application. The specialties should revise 99183 to be time-based well as modified to appropriately describe the treatment delivery, attendance and supervision or develop a coding change creating a practice expense only code to capture the service appropriately and eliminate the need for G0277.**

II. Practice Expense Screen

At the April 2023 Relativity Assessment Workgroup, a member questioned what practice expense screens may be developed to identify high practice expense and/or anomalies. AMA staff indicated that the RUC has conducted various PE screens such as Services with Stand-Alone PE Procedure Time, High Cost Supplies and PE Units Screen. AMA staff summarized the previous PE screens and the Workgroup recommended lowering the Medicare allowed charges threshold from $100,000 to $50,000 for the Services with Stand-Alone PE Procedure Time screen, for codes that have 0.00 work RVUs, including direct equipment inputs that total in direct expense to the individual code to $100 or more, and have PE procedure times (CA021) greater than five minutes.

The Relativity Assessment Workgroup reviewed the services identified via this screen at the January 2024 meeting and noted that 77372 and 77373 appeared on the first CMS iteration of this screen and were validated in April 2013. Additionally, the radiation treatment delivery codes identified (G6004-G6016) are currently referred to the CPT May 2024 meeting for revision, therefore the stand alone PE procedure time will be reviewed when these services go through the RUC process. **Lastly, codes 93229 and 93271 were identified and the Workgroup requests an action plan on how to best address these services.**

III. Informational Items

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

AMA/Specialty Society RVS Update Committee **Tab 17**
Multi-Specialty Points of Comparison (MPC) Workgroup
January 18, 2024

Members: Amr Abouleish, MD (Chair), Jennifer Aloff, MD, Anita Arnold, DO, Charles Fitzpatrick, OD, Alexandra Flamm, MD, Gregory Harris, MD John Heiner, MD, Gwenn Jackson, MD, Kristopher Kimmell, MD, Howard P. Levy, MD, PhD, Bradley Marple, MD, John Proctor, MD, Kyle Richards, MD

Review of the Service to Sunset off MPC List and Specialty Code Recommendations

The MPC Workgroup members reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list. Participating specialty societies used a submission form requested during Other Business at the January 2023 MPC Workgroup meeting to complete their code recommendations. This submission form includes a checklist of the applicable absolute and suggested criteria and a comment box for a more granular rationale for each code submission. Representatives from specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members noted that specialty societies should be encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list. The MPC Workgroup reminded the specialty societies that any specialty with 10% or more utilization of the code should comment on the appropriateness of addition or deletion of a code.

The MPC Workgroup members agreed to maintain 3 codes, delete 11 codes, and add 7 codes to the MPC list with justification provided by specialty societies in their recommendations.

I. Review of Services to Sunset – Recommendation to Maintain Codes on MPC List

In June 2021, the MPC Workgroup recommended to identify and review codes on the MPC list that have not been reviewed in the last 15 years as part of its annual review. There were 14 services on the MPC list that have not been RUC reviewed in the last 15 or more years. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "maintain" or "delete" these services, along with their supporting rationale.

The American Academy of Audiology recommended to maintain three services, 92567, 92568 and 92604, on the MPC list, to which the MPC Workgroup agreed. These services will be flagged for review next year per the 15+ year sunset screen.

The MPC Workgroups recommends maintaining the following 3 services:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2023 Frequency
92567	Tympanometry (impedance testing)	0.20	XXX	2007-04	876,262
92568	Acoustic reflex testing, threshold	0.29	XXX	2007-04	2,572
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	1.25	XXX	2007-04	26,542

The American College of Radiology, Outpatient Endovascular and Interventional Society and Society of Interventional Radiology submitted a recommendation to maintain two services, 49440 and 50593, on the MPC list. The MPC Workgroup disagreed with the submission to maintain these services on the MPC list and recognized that both services were valued based on a building block methodology and not supported by survey.

The remaining 9 services (99406, 99407, 46600, 51797, 92002, 92012, 92014, 92004 and 33207) set to sunset off the MPC list did not receive any specialty society response to maintain, thus the Workgroup agreed to delete them from the MPC list.

The MPC Workgroups recommends deleting the following 11 services:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2023 Frequency
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	0.24	XXX	2007-04	347,358
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	0.50	XXX	2007-04	58,311
46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	0.55	000	2007-02	90,136
51797	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	0.80	ZZZ	2007-02	93,588
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	0.88	XXX	2007-02	137,534
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	0.92	XXX	2007-02	3,753,292
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	1.42	XXX	2007-02	9,318,453
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	1.82	XXX	2007-02	1,783,777
49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.93	010	2007-09	19,888
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	7.80	090	2007-04	9,237

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2023 Frequency
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	8.88	010	2007-04	3,517

II. MPC List Services Additions

The MPC Workgroup annually solicits the specialty societies for codes that should be added to or deleted from the MPC list. There were 8 services recommended for addition to the MPC list by four participating specialty societies**.**

The American College of Chest Physicians and American Thoracic Society recommended adding code 94010 to the MPC list, to which the MPC Workgroup agreed. The American Society of Regional Anesthesia and Pain Medicine recommended addition of four services, 27096, 64415, 62324 and 64625, to the MPC list. The MPC Workgroup agreed with the addition of 64415, 62324 and 64625 but disagreed with adding 27096. The Workgroup noted that 27096 was valued by crosswalk and is not survey supported, but unlike 64625, the service does not fill a work RVU gap on the MPC list and thus does not enhance the MPC list. The American Academy of Ophthalmology recommended addition of three services, 67914, 67917 and 67036, to the MPC list, to which the MPC Workgroup agreed.

The MPC Workgroup recommends adding the following 7 services to the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2023 Frequency
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	0.17	XXX	2019-10	785,243
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	1.50	000	2021-10	192,508
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	1.89	000	2015-10	10,995
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	3.39	010	2019-01	28,924
67914	Repair of ectropion; suture	3.75	090	2013-04	1,353

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2023 Frequency
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	5.93	090	2013-04	19,453
67036	Vitrectomy, mechanical, pars plana approach;	12.13	090	2013-10	17,654

The MPC Workgroup does not recommend adding the following service to the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2023 Frequency
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	1.48	000	2011-04	445,760

III. Other Business

The Workgroup noted that the submission form specialties used for submitting changes to the MPC list helped facilitate review of the MPC list. AMA staff will solicit feedback from the specialty societies prior to the next meeting for further refinement.

The Workgroup discussed future review of the Suggested Criteria listed in the MPC Summary of Process. It was suggested that developing a hierarchy to more effectively address any potential gaps in the criteria would be beneficial to the review process. An example would be when to include a code on the MPC list that was valued by a crosswalk and not by survey: a proposed code for addition to the MPC list that was valued by crosswalk may be appropriate to add if it fills a work RVU gap on the MPC list. Future discussion of this topic will occur after the specialty societies are solicited for further review of the submission form and their feedback is compiled by AMA staff.

The Workgroup Chair recommended another addition to the Suggested Criteria wherein codes that were surveyed within the last 10 years are preferred and given preference over those that were surveyed more than 10 years ago. It was noted in discussion that this suggested criterion may prevent less turnover on the MPC list with respect to the 15-year or more sunset review and prioritize including more recent codes.

Members Present: Peter Hollmann, MD *(Chair),* Richard Rausch, DPT, MBA *(Co-Chair),* Leisha Eiten, AuD, CCC-A *(Alt. Co-Chair),* Amr Abouleish, MD, Kris Anderson, DC, MS, Brooke Bisbee, DPM, Luis Riquelme, PhD, CCC-SLP, Charles Fitzpatrick, OD, Scott Sperling, PsyD ABPP-CN, Katie Jordan, OTD, OTR/L, Paul Pessis, AuD, Karen Smith, MS, MBA, RD, LD, FADA, Nelda Spyres, LCSW, Elisabeth Volpert, DNP, APRN, FNP-BC, Robert Zwolak, MD

I. Introductions and CMS

Doctor Rausch welcomed the Health Care Professionals Advisory Committee (HCPAC) to the in-person meeting.

II. CMS Request/Relativity Assessment Identified Codes

Physical Medicine & Rehabilitation (PE Only)

In February 2017, the RUC HCPAC Review Board submitted recommendations for 19 Physical Medicine and Rehabilitation codes. At the time, the RUC HCPAC considered the typical number of services reported per session, which was 3.5 units based on CMS data, to ensure there was no duplication in the standard inputs for pre and post time. Based on 2022 Medicare data, a mean value of 3.5 codes are reported per session, which is consistent with the 2017 review, and will be used to re-review the RUC HCPAC recommendations for this code family. Therefore, the RUC placed the nominated therapy codes on the CMS / Relativity Assessment Workgroup level of interest to review the practice expense inputs at the January 2024 RUC HCPAC meeting.

Compelling Evidence
In the Notice of Proposed Rulemaking for 2024, CMS received public nominations on 19 therapy codes as potentially misvalued. An interested party asserted that the direct PE clinical labor minutes, as recommended by RUC HCPAC, reflected inappropriate multiple procedure payment reductions (MPPR), which are likely duplicative of the CMS MPPR policy implemented in CMS' claims processing systems. CMS reviewed the clinical labor time entries for these 19 therapy codes noting that they did not believe a payment reduction should have been applied in some instances to the 19 nominated therapy codes' clinical labor time entries since the payment valuation reduction would be duplicative of the MPPR applied during claims processing. CMS indicated that the valuation of these services would benefit from additional review through the AMA RUC HCPAC valuation process. **The Practice Expense Subcommittee and HCPAC Review Board accepted compelling evidence based on the potentially misvalued designation.**

Modalities

For each modality service, the PT/OT Aide greets patient, provides and, if needed assists with appropriate gowning, draping for performance of the procedure. The Aide procures and sets up any necessary space, equipment, and supplies for the procedure. Further, the aide will prepare and position the patient in preparation for the procedure and provide any additional physical assistance. During the procedure, the Aide will assist the Therapist with supplies and at the end of the procedure the aide will clean all equipment and dispose of supplies. The modality services CPT codes are almost always reported with other services that also include clinical labor time for several of the clinical same clinical activities. Therefore, the PE Subcommittee and the HCPAC accounted for the typical number of codes reported on the claim and the impact of the therapy multiple procedure payment reductions on applicable clinical activities as follows.

Supervised (97012-97022, G0283)

For the following inputs, the specialty societies and HCPAC agreed that 1.33 minutes is appropriate:

- CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* the standard clinical staff time is 3 minutes.
- CA013 *Prepare room, equipment and supplies*
- CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*
- CA024 *Clean room/equipment by clinical staff*

CA010 and CA35 are not applicable to the supervised modalities.

Further, in this circumstance, the MPPR would be applied to avoid overlapping minutes but ensure correct valuation depending on a given session scenario where the typical 3.5 codes are reported. To account for the MPPR, it was determined that 3.5 codes are billed per session and the first is paid at 100% and the second and subsequent units get paid at half and so forth for practice expense. For example, for the three most common scenarios, shown in the table below, the total number of minutes for any of the relevant clinical staff activities would be approximately 3 minutes for CPT codes 97012, 97014/G0283, 97016, 97018, and 97022 when billed with a therapy code.

% of Medicare Claims	1	2	3	4	Number of CPT/HCPCS Codes on Claim
10%	97110	97110	97140		3
8%	97110	97110	97112	97140	4
8%	97110	97110	97112	97530	4

**Please see the full table under Table 1 in the Appendix.*

The specialty societies and HCPAC agreed that the 2 minutes for the PT Aide for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%)* instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97012, 97014/G0283, 97016, 97018, and 97022.

The specialty societies and HCPAC agreed on the existing medical supplies for CPT codes 97012, 97014/G0283, 97016, 97018, and 97022. However, the equipment inputs for each supervised modality code were revised by the HCPAC to be consistent with the intra-service time or the default formula, whichever was higher, to appropriately account for the actual time utilizing the given equipment.

The HCPAC recommends the direct practice expense inputs for CPT codes 97012, 97014, 97016, 97018, 97022 and HCPCS code G0283 as modified by the HCPAC and Practice Expense Subcommittee.

Constant Attendance (97032-97035)

For the following inputs, the specialty societies and HCPAC agreed that 1.33 minutes is appropriate:
- CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* the standard clinical staff time is 3 minutes.
- CA013 *Prepare room, equipment and supplies*
- CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*
- CA024 *Clean room/equipment by clinical staff*

CA010 and CA35 are not applicable to the constant attendance modalities.

To account for the MPPR, and given that 3.5 codes are typically billed per session, 1.33 minutes is appropriate for CPT codes 97032, 97033, 97034, and 97035 when billed in any given session.

For CA029 *Check dressings, catheters, wounds* the specialty societies and HCPAC agreed that 1 minute is appropriate for CPT codes 97033 and 97035 which is consistent with the current and standard input and necessary to assess the integrity of the skin.

The specialty societies and HCPAC agreed on the existing medical supplies for CPT codes 97032, 97033, 97034, and 97035. However, the equipment inputs for each constant attendance modality code were revised by the HCPAC to be consistent with the intra-service time or the default formula, whichever was higher, to appropriately account for the actual time utilizing the given equipment.

The HCPAC recommends the direct practice expense inputs for CPT codes 97032, 97033, 97034, and 97035 as modified by the HCPAC and Practice Expense Subcommittee.

Therapeutic Procedures (97110-97140) & Activities of Daily Living (ADL) (97530-97542)

During the Therapeutic Procedures, the PT/OT Assistant often assists the clinician with obtaining and recording measures. This may include recording performance data, physical facilitation with the patient, grading challenges in environment, and other clinical assistance throughout the session. An assistant provides the clinically appropriate support for the patient as the therapist facilitates the performance in therapeutic exercise, neuromuscular re-education, gait training, aquatic therapy, manual therapy, therapeutic activities, and wheelchair management. The PT/OT Aide assists with re-positioning the patient, adjusting equipment throughout the procedure, cleaning equipment and surfaces as well as providing physical assistance as needed. The PE Subcommittee and the HCPAC observed that these clinical activities are included in multiple codes typically reported on the same claim, and agreed to account for the typical number of code units and the impact of the therapy MPPR accordingly.

For the following inputs, the specialty societies and HCPAC agreed that 1.33 minutes is appropriate:

- CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* the standard clinical staff time is 3 minutes.
- CA010 *Obtain vital signs*
- CA013 *Prepare room, equipment and supplies*
- CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*
- CA024 *Clean room/equipment by clinical staff*
- CA035 *Review home care instructions, coordinate visits/prescriptions*

To account for the MPPR, and given that 3.5 codes are billed per session, 1.33 minutes is appropriate for CPT codes CPT codes 97110, 97112, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 when billed in any given session.

For CPT code 97113, which is typically reported on the claim with a median of 3 units and not typically reported with other therapy or modality codes, it was determined that 1.5 minutes was appropriate for CA009, CA010, CA016, and CA035 to conduct aquatic therapy. Further, it was determined that 4 minutes is appropriate for CA013 to appropriately prepare the aquatic therapy pool and aquatic exercise kit and 6 minutes for CA024 to clean the aquatic therapy pool and aquatic exercise kit, respectively. For CA018 *Assist physician or other qualified healthcare professional—directly related to physician work time (100%)* 15 minutes is necessary as there must always be two individuals in the pool with the patient for the entire procedure for CPT code 97113.

The specialty societies and HCPAC agreed that 2.5 minutes for the PT Assistant and 5 minutes for the PT Aide for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%*) instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97110, 97112, 97116, and 97140. For CPT code 97113, 2 minutes of for the PT

Aide for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%)* instead of CA021 *Perform procedure/service—NOT directly related to physician work time* for both the PT Aide and PT Assistant.

The specialty societies and HCPAC agreed that 3.75 minutes for the PT Assistant and for the PT Aide, respectively, for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%)* instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97530 and 97542. Further, 7.5 minutes for the PT Assistant for CA020 *Assist physician or other qualified healthcare professional—directly related to physician work time (other%)* instead of CA021 *Perform procedure/service—NOT directly related to physician work time* is appropriate for CPT codes 97533, 97535, and 97537.

For CA029 *Check dressings, catheters, wounds* the specialty societies and HCPAC agreed that 1 minute is appropriate for CPT codes 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 which is consistent with the standard input. This is a reduction based on the current input of 1.5 minutes. Further, the recommended 1 minute is justified given that this time is spent checking the integrity of the skin for each separate procedure performed.

CA033 *Perform regulatory mandated quality assurance activity (service period)* is no longer standard practice for CPT code 97113 and therefore the recommendation of 0 minutes is appropriate.

The specialty societies and HCPAC agreed on the existing medical supply inputs for CPT codes 97113, 97140, 97530, 97533, 97535, 97537, and 97542. However, for CPT codes 97110, 97112, and 97116, it was agreed that 0.9 was appropriate for SJ056 *Thera-bands (6in width)* instead of the existing input. This is due to the fact that 20 ft of Thera-bands are provided during a normal 10 visit treatment plan, that would equate to a proxy of 2 ft provided per visit. Therefore, 0.9 is appropriate to account for the MPPR reduction (0.9 + 0.45 + 0.45 + 0.225 = ~2).

For CPT codes 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 the equipment inputs were revised by the HCPAC to be consistent with the intra-service time or the default formula, whichever was higher, to appropriately account for the actual time utilizing the given equipment.

The HCPAC recommends direct practice expense inputs for CPT codes 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, and 97542 as modified by the HCPAC and Practice Expense Subcommittee.

III. Multi-Specialty Points of Comparison (MPC) List Updates

The HCPAC Review Board reviewed the addition of CPT codes 96113 and 96202 to the HCPAC Multi-Specialty Points of Comparison (MPC) list. **After review of the suggested criteria, the HCPAC voted to accept the addition of CPT code 96113 to the HCPAC MPC list given that it met the majority of absolute and suggested criteria (see table).**

CPT Code	CPT Descriptor	Global	Work RVU	Last Reviewed
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	ZZZ	1.16	October 2017

CPT code 96202 *Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes* (work RVU = 0.63) was also considered for the HCPAC list. However, with recent CMS acceptance in the CY 2024 Final Rule, the code lacks Medicare related data related to the top specialty, utilization, and billed together information, therefore not meeting the majority of the absolute and suggested criteria. For these reasons, the code was not added to the HCPAC MPC list, however, the HCPAC was amenable to considering CPT codes 96202 and 96203 after 1 year of data is available. Given this decision, CPT code 96203 *Multiple-family group behavior modification/management training for guardians/caregivers of a patient with a mental or physical health diagnosis, administered by physician or other qualified nonphysician health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.12) was withdrawn at the table with the notion that it may be considered at a later date once data is available.

Prior to the meeting the following codes were withdrawn from consideration for the HCPAC MPC list by the submitting specialty societies:

- 90846 *Family psychotherapy (without the patient present), 50 minutes*
- 90847 *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes*
- 96158 *Health behavior intervention, individual, face-to-face; initial 30 minutes*
- 96159 *Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)*

IV. Other Business

There were no new business items brought forth.

Appendix

Table 1. Physical Medicine & Rehabilitation Medicare Claims Data

	% of Medicare Claims	1	2	3	4	5	Codes on Claim	All Codes have Same Recommended Time for Greet Patient, Vitals, Prepare room/ Equip, Positioning, Clean Room, Review Home Care
	10%	97110	97110	97140			3	Yes
	8%	97110	97110	97112	97140		4	Yes
	8%	97110	97110	97112	97530		4	Yes
	5%	97110	97110	97140	97530		4	Yes
	5%	97110	97110	97530			3	Yes
	5%	97110	97112	97140	97530		4	Yes
	4%	97110	97110	97112			3	Yes
	4%	97110	97110	97140	G0283		4	G0283 is different
	3%	97110	97110	97110			3	Yes
	2%	97112	97112	97530			3	Yes
	2%	97110	97112	97140	G0283		4	G0283 is different
	2%	97112	97140	97140	97530		4	Yes
	2%	97110	97112	97116			3	Yes
	1%	97110	97110	97116	97530		4	Yes
	1%	97110	97112	97116	97530		4	Yes
	1%	97140	97530				2	Yes
	1%	97110	97140	97530	G0283		4	G0283 is different
	1%	97112	97112	97140			3	Yes
	1%	97530	97530				2	Yes
	1%	97110	97112	97140	97530	G0283	5	G0283 is different
Percent of Medicare Claims w/ Tab 18 codes	68%							

AMA/Specialty Society RVS Update Committee **Tab 04**
04 Skin Cell Suspension Autograft
Facilitation Committee #1

Members: James Blankenship, MD (Chair), Margie Andreae, MD, Michael Perskin, MD, Joseph Cleveland, MD, William Donovan, MD, Matthew Grierson, MD, David Han, MD, Richard Rausch, DPT, Thomas Weida, MD

The Facilitation Committee evaluated the new Skin Cell Suspension Autograft codes and determined that:

- Median survey times and physician work values should be applied across the family of codes as supported by the survey.
- Duplicative pre-service time should be removed.
- Number and intensity of inpatient and outpatient post-operative visits are appropriate.

Tab 04 Skin Cell Suspension Autograft Table

Code	Global	Pre	Intra	Immediate Post	99232 Hospital Visit	99238 Discharge Visit	99213 Post-Op Office Visit	Total	Work RVU
15XX1	000	80	40	20				140	**3.00**
15XX2	ZZZ	0	40	0				40	**2.00**
15XX3	XXX	0	33	0				33	**2.51**
15XX4	ZZZ	0	28	0				28	**2.00**
15XX5	090	0	83	30	4	1	4	403	**10.97**
15XX6	ZZZ	0	25	0				25	**2.50**
15XX7	090	0	75	30	4	1	4	395	**12.50**
15XX8	ZZZ	0	30	0				30	**3.00**

15XX1 ***Harvest of skin for skin cell suspension autograft; first 25 sq cm or less***
The Facilitation Committee reviewed the survey results from 33 burn surgeons and determined that the survey median work RVU of 3.00 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 55 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 40 minutes intra-service time, and 20 minutes immediate post-service time for 140 minutes of total time.

The pre-service time includes 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time and 10 minutes scrub/dress/wait time that were moved from CPT codes 15XX5 and 15XX7. This reallocation is appropriate as the harvest base code will always be paired with one of the two base application codes during an episode of care. CPT code 15XX1 now includes all the pre-service time for this episode of care. The Facilitation Committee agreed this change supports the flow of work.

To support the median value for CPT code 15XX1, comparable codes are MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.55, 40 minutes intra-service time and 78 minutes total time) and CPT code 32408 *Core needle biopsy, lung or mediastinum, percutaneous, including imaging*

guidance, when performed (work RVU = 3.18, 40 minutes intra-service time and 101 minutes total time). **The Facilitation Committee recommends a work RVU of 3.00 for CPT code 15XX1.**

15XX2 ***Harvest of skin for skin cell suspension autograft; each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure)***
The Facilitation Committee reviewed the survey results from 33 burn surgeons and determined that the survey median work RVU of 2.00 appropriately accounts for the work involved in this add-on service. The Facilitation Committee recommends 40 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15XX2, comparable codes are CPT code 20937 *Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)* (work RVU = 2.79, 40 minutes intra-service time and total time) and CPT code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 2.19, 35 minutes intra-service time and total time). **The Facilitation Committee recommends a work RVU of 2.00 for CPT code 15XX2.**

15XX3 ***Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin***
The Facilitation Committee reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 2.51 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 33 minutes intra-service and total time. The Committee removed the pre-service evaluation time from code 15XX3 as it determined that only 15XX1 should have pre-time. CPT code 15XX1 now includes all the pre-service time for this episode of care.

To support the median value for CPT code 15XX3, comparable codes are MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time) and CPT codes 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time) and 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time). **The Facilitation Committee recommends a work RVU of 2.51 for CPT code 15XX3.**

15XX4 ***Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure)***
The Facilitation Committee reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 2.00 appropriately accounts for the work involved in this add-on service. The Facilitation Committee recommends 28 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15XX4, comparable codes are CPT code 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (work RVU = 2.23, 30 minutes intra-service time and total time) and CPT code 49435 *Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (List separately in addition to code for primary procedure)* (work RVU = 2.25, 30 minutes intra-service time and total time). **The Facilitation Committee recommends a work RVU of 2.00 for CPT code 15XX4.**

15XX5 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; first 480 sq cm or less***
The Facilitation Committee reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 10.97 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 83 minutes intra-service time and 403 minutes total time including 30 minutes of immediate post-service time, 4-99232 subsequent hospital inpatient visits, 1-99238 discharge visit, and 4-99213 post-operative office visits. The Facilitation Committee reallocated the pre-service time from the surveyed code to 15XX1 as the harvest base code will always be paired with one of the two base application codes during an episode of care.

The Facilitation Committee expressed concern regarding the negative IWPUT for code 15XX5 (-0.005) and considered adjusting the post-operative visits to resolve this issue. However, the Committee was convinced by the cogent arguments from the specialty that the number and intensity of the post-operative visits should be maintained for this critically ill patient population. Both the inpatient and outpatient visits were determined to be appropriate.

To support the median value for CPT code 15XX5, comparable codes are CPT code 34490 *Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision* (work RVU = 10.91, 80 minutes intra-service time and 367 minutes total time) and CPT code 32097 *Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 13.75, 80 minutes intra-service time and 401 minutes total time). **The Facilitation Committee recommends a work RVU of 10.97 for CPT code 15XX5.**

15XX6 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)***
The Facilitation Committee reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 2.50 appropriately accounts for the work involved in this add-on service. The Facilitation Committee recommends 25 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15XX6, comparable codes are CPT code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU = 2.50, 25 minutes intra-service time and 32 minutes total time) and CPT codes 32506 *Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* (work RVU = 3.00, 25 minutes intra-service time and total time) and 36907 *Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)* (work RVU = 3.00, 25 minutes intra-service time and total time). **The Facilitation Committee recommends a work RVU of 2.50 for CPT code 15XX6.**

15XX7 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less***
The Facilitation Committee reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 12.50 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 75 minutes intra-service time and 395 minutes total time including 30 minutes of immediate post-service time, 4-99232 subsequent hospital inpatient visits, 1-99238 discharge visit, and 4-99213 post-operative office visits. The Facilitation Committee reallocated the pre-service time from the surveyed code to 15XX1 as the harvest base code will always be paired with one of the two base application codes during an episode of care.

To support the median value for CPT code 15XX7, comparable codes are CPT code 27540 *Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed* (work RVU = 11.30, 75 minutes intra-service time and 334 minutes total time) and CPT code 50205 *Renal biopsy; by surgical exposure of kidney* (work RVU = 12.29, 75 minutes intra-service time and 324 minutes total time). **The Facilitation Committee recommends a work RVU of 12.50 for CPT code 15XX7.**

15XX8 ***Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)***
The Facilitation Committee reviewed the survey results from 30 burn surgeons and determined that the survey median work RVU of 3.00 appropriately accounts for the work involved in this add-on service. The Facilitation Committee recommends 30 minutes intra-service time as supported by the survey.

To support the median value for CPT code 15XX8, comparable codes are CPT code 64913 *Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)* (work RVU = 3.00, 30 minutes intra-service time and total time) and CPT codes 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, 30 minutes intra-service time and total time) and 47543 *Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)* (work RVU = 3.00, 30 minutes intra-service time and total time). **The Facilitation Committee recommends a work RVU of 3.00 for CPT code 15XX8.**

The Facilitation Committee acknowledged the recommendations of the Practice Expense (PE) Subcommittee. The Specialty modified its recommendation to price in the facility only. These recommendations will be flagged to review after one year of claims data to determine whether the dominant specialty is different in the non-facility. **The Facilitation Committee recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee for the facility setting only and recommends that the one-year review of CPT codes 15XX1-15XX8 include both work and PE.**

The Facilitation Committee recommends that CPT codes 15XX1-15XX8 be flagged in the RUC database to not be used to validate physician work.

The Facilitation Committee recommends that CPT codes 15XX1-15XX8 be placed on the New Technology list to be re-reviewed by the RUC and notes that the codes should be reviewed after ONE year of claims data.

The RUC understands that the specialties intend to go to CPT with changes that distinguish services that require extensive post operative care from lesser procedures.

SS Rec Summary

ISSUE: Skin Cell Suspension Autograft
TAB: 4

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15040	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	000	2005	22	0.073	0.031			2.00			65	15	10	15			15			10															
2nd REF	15002	Surgical preparation or creation of recipient site by excision of open	000	2006	2	0.087	0.032			3.65			115	45	15	15			20			20															
SVY	15XX1	Harvest of skin for skin cell suspension autograft, first 25 sq	000	New	33	0.019	0.020	0.80	2.00	3.00	4.00	4.50	152	60	12	20	5	30	40	180	480	20												0	13	43	50	300
TGTD SVY	15XX1	Harvest of skin for skin cell suspension autograft, first 25 sq	000	New	17	0.001	0.016	0.80	1.53	2.50	4.00	4.50	160	45	20	15	5	26	40	180	240	40												0	13	50	55	300
RNDM SVY	15XX1	Harvest of skin for skin cell suspension autograft, first 25 sq	000	New	16	0.019	0.019	2.00	2.00	3.00	4.00	4.00	155	60	12	23	15	40	45	180	480	15												0	10	36	50	122
REC	15XX1	Harvest of skin for skin cell suspension autograft, first 25 sq	000	New		0.023	0.021			3.00			140	55	15	10			40			20															

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq	ZZZ	1998	14	0.059	0.059			1.72			29						29																			
2nd REF	15152	Tissue cultured skin autograft, trunk, arms, legs; each additional	ZZZ	2005	3	0.125	0.125			2.50			20						20																			
SVY	15XX2	Harvest of skin for skin cell suspension autograft, each	ZZZ	New	33	0.050	0.050	0.33	1.00	2.00	2.50	3.75	40				3	18	40	60	120														0	1	15	88	400
TGTD SVY	15XX2	Harvest of skin for skin cell suspension autograft, each	ZZZ	New	17	0.050	0.050	0.80	0.90	1.50	2.50	4.50	30				3	14	30	60	120														0	1	6	16	60
RNDM SVY	15XX2	Harvest of skin for skin cell suspension autograft, each	ZZZ	New	16	0.042	0.042	0.33	1.61	2.50	2.50	3.00	60				10	23	60	60	81														0	3	20	25	122
REC	15XX2	Harvest of skin for skin cell suspension autograft, each	ZZZ			0.050	0.050			2.00			40						40																			

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	99204	Office or other outpatient visit for the evaluation and management of	XXX	2019	5	0.043	0.043			2.60			60	10	0	0			40			10															
2nd REF	99214	Office or other outpatient visit for the evaluation and management of	XXX	2019	3	0.041	0.041			1.92			47	7	0	0			30			10															
SVY	15XX3	Preparation of skin cell suspension autograft, requiring enzymatic	XXX	New	30	0.059	0.043	0.50	2.00	2.51	4.00	4.60	58	10	0	0	5	18	33	49	120	15												1	5	15	50	200
TGTD SVY	15XX3	Preparation of skin cell suspension autograft, requiring enzymatic	XXX	New	18	0.059	0.043	1.50	1.91	2.51	3.28	4.50	58	10	0	0	10	24	33	45	120	15												2	9	26	50	200
RNDM SVY	15XX3	Preparation of skin cell suspension autograft, requiring enzymatic	XXX	New	12	0.081	0.055	0.50	1.50	3.00	4.25	4.60	55	15	0	0	5	20	30	45	75	10												1	2	18	45	100
REC	15XX3	Preparation of skin cell suspension autograft, requiring enzymatic	XXX			0.076	0.076			2.51			33	0					33			0															

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15152	Tissue cultured skin autograft, trunk, arms, legs; each additional	ZZZ	2005	6	0.091	0.050			2.50			50						20			30															
2nd REF	15116	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits,	ZZZ	2005	3	0.071	0.071			2.50			35	0	0	0			35			0															
SVY	15XX4	Preparation of skin cell suspension autograft, requiring enzymatic	ZZZ	New	28	0.071	0.071	0.30	1.36	2.00	3.20	4.00	28	0	0	0	5	15	28	49	70	0												1	5	12	53	200
TGTD SVY	15XX4	Preparation of skin cell suspension autograft, requiring enzymatic	ZZZ	New	18	0.071	0.071	0.30	1.50	2.00	2.60	3.70	28	0	0	0	10	15	28	60	70	0												1	5	15	58	200
RNDM SVY	15XX4	Preparation of skin cell suspension autograft, requiring enzymatic	ZZZ	New	12	0.067	0.067	0.41	1.25	2.00	3.00	4.00	30	0	0	0	5	15	30	35	69	0												0	2	13	45	122
REC	15XX4	Preparation of skin cell suspension autograft, requiring enzymatic	ZZZ			0.071	0.071			2.00			28						28																			

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1%	90	2005	16	0.091	0.036			10.97			306	20	20	10			28			20			4				3									
2nd REF	15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less,	90	2005	9	0.053	0.035			9.90			281	45	10	10			60			20			0	1	1.0		2	2							

SS Rec Summary

TAB: 4

					RUC Review			Work Per	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch					Office			SURVEY EXPERIENCE				
SVY	15XX5	Application of skin cell suspension autograft to wound and donor sites,	90	New	30	-0.022	0.023	5.00	10.50	10.97	12.75	19.00	473	45	15	10	10	28	83	98	240	30	4		1.0	0	4	0	0	9	30	58	200
TGTD SVY	15XX5	Application of skin cell suspension autograft to wound and donor sites,	90	New	16	-0.025	0.024	8.00	10.50	11.50	15.00	18.37	482	45	15	10	10	30	75	90	240	30	4		1.0	1	3	0	0	6	30	50	200
RNDM SVY	15XX5	Application of skin cell suspension autograft to wound and donor sites,	90	New	14	-0.015	0.023	8.00	10.50	10.97	12.00	19.00	473	45	15	10	15	56	90	98	189	30	4		1.0	3	1		0	0	0	1	20
REC	15XX5	Application of skin cell suspension autograft to wound and donor sites,	90			-0.005	0.027	10.97					403	0	0	0			83			30	4		1.0	4								

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15116	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits,	ZZZ	2006	14	0.071	0.071			2.50			35	0	0	0			35			0														
2nd REF	15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq	ZZZ	1998	8	0.059	0.059			1.72			29	0	0	0			29			0														
SVY	15XX6	Application of skin cell suspension autograft to wound and donor sites,	ZZZ	New	30	0.100	0.100	1.75	2.37	2.50	8.88	10.97	25	0	0	0	10	15	25	65	200	0											0	6	25	88	200
TGTD SVY	15XX6	Application of skin cell suspension autograft to wound and donor sites,	ZZZ	New	16	0.100	0.100	1.80	2.00	2.50	6.00	9.25	25	0	0	0	10	15	25	45	200	0											0	6	30	70	200
RNDM SVY	15XX6	Application of skin cell suspension autograft to wound and donor sites,	ZZZ	New	14	0.138	0.138	1.00	2.00	2.75	9.44	10.97	20	0	0	0	10	11	20	78	120	0											0	5	15	88	120
REC	15XX6	Application of skin cell suspension autograft to wound and donor sites,	ZZZ			0.100	0.100	2.50					25						25																	

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15115	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits,	90	2006	16	0.044	0.032			11.28			356	20	20	15			35			20			4	0	1.0				3						
2nd REF	15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears,	90	2010	10	0.068	0.039			10.15			258	40	12	20			75			30					0.5		2	1							
SVY	15XX7	Application of skin cell suspension autograft to wound and donor sites,	90	New	30	-0.004	0.027	6.00	11.45	12.50	15.00	21.28	465	45	15	10	10	16	75	120	360	30	4			1.0		0	4				0	6	15	30	150
TGTD SVY	15XX7	Application of skin cell suspension autograft to wound and donor sites,	90	New		0.006	0.028	6.00	11.28	12.50	15.00	21.28	444	45	15	10	10	16	75	120	240	30	4					1	3				0	5	15	20	150
RNDM SVY	15XX7	Application of skin cell suspension autograft to wound and donor sites,	90	New		0.022	0.032	6.00	11.40	12.50	20.30	21,28	396	30	10	10	16	43	75	75	189	19	4					4					3	6	15	50	105
REC	15XX7	Application of skin cell suspension autograft to wound and donor sites,	90			0.015	0.032	12.50					395	0	0	0			75			30	4			1.0			4							

Source	CPT	DESC	Global	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15116	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits,	ZZZ	2006	11	0.071	0.071			2.50			35	0	0	0			35			0														
2nd REF	15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears,	ZZZ	2010	11	0.067	0.067			2.00			30	0	0	0			30			0														
SVY	15XX8	Application of skin cell suspension autograft to wound and donor sites,	ZZZ	New	30	0.100	0.100	2.00	2.50	3.00	9.50	12.50	30	0	0	0	5	20	30	65	180	0											0	6	15	33	200
TGTD SVY	15XX8	Application of skin cell suspension autograft to wound and donor sites,	ZZZ	New		0.125	0.125	2.00	13.88	3.75	10.00	12.50	30	0	0	0	5	15	30	30	180	0											0	6	15	25	200
RNDM SVY	15XX8	Application of skin cell suspension autograft to wound and donor sites,	ZZZ	New		0.125	0.125	1.00	9.08	2.50	8.13	11.28	20	0	0	0	5	20	20	79	180	0											0	6	40	68	80
REC	15XX8	Application of skin cell suspension autograft to wound and donor sites,	ZZZ			0.100	0.100	3.00					30						30																	