

AMA/Specialty Society RVS Update Committee
October 7-10, 2020

Meeting Minutes

I. Welcome and Call to Order

The RUC met virtually in October 2020 due to the COVID-19 pandemic. Doctor Peter Smith called the virtual meeting to order on Thursday, October 8, 2020 at 9:00 a.m. CT. The following RUC Members were in attendance:

Peter K. Smith, MD	Amr Abouleish, MD, MBA*
Margie C. Andraeae, MD	Amy Aronsky, DO*
Michael D. Bishop, MD	Jennifer Aloff, MD*
James Blankenship, MD	Gregory L. Barkley, MD*
Robert Dale Blasier, MD	Eileen Brewer, MD*
Kathleen K. Cain, MD	Joseph Cleveland, MD*
Jim Clark, MD	William D. Donovan, MD, MPH*
Scott Collins, MD	William F. Gee, MD*
Gregory DeMeo, DO	David C. Han, MD*
Verdi J. DiSesa, MD	John Heiner, MD*
Jeffrey P. Edelstein, MD	Peter Hollmann, MD*
Matthew J. Grierson, MD	Gwenn V. Jackson, MD*
Gregory Harris, MD	S. Kalyan Katakam, MD, MPH*
David F. Hitzeman, DO	Mollie MacCormack, MD*
Omar S. Hussain, DO	Lance Manning, MD*
Timothy Laing, MD	John McAllister, MD*
Alan Lazaroff, MD	Eileen Moynihan, MD*
M. Douglas Leahy, MD	M. Eugene Sherman, MD*
Scott Manaker, MD, PhD	James L. Shoemaker, MD*
Bradley Marple, MD	Clarice Sinn, DO*
Dee Adams Nikjeh, PhD, CCC-SLP	Michael J. Sutherland, MD*
Jordan Pritzker, MD	Donna Sweet, MD*
John H. Proctor, MD, MBA	Timothy H. Tillo, DPM*
Marc Raphaelson, MD	Mark T. Villa, MD*
Christopher Senkowski, MD	David Wilkinson, MD, PhD*
Ezequiel Silva III, MD	David Yankura, MD*
Norman Smith, MD	
Stanley W. Stead, MD, MBA	
G. Edward Vates, MD	
James C. Waldorf, MD	
Thomas J. Weida, MD	

*Alternate

II. Chair's Report

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

- Doctor Smith conveyed the following guidelines related to Confidentiality:
 - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement electronically prior to this meeting).
 - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
 - Recording devices are prohibited.
 - Full confidentiality agreement found on Collaboration site (Structure and Functions).
- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff:
 - Perry Alexion, MD - Medical Officer
 - Edith Hambrick, MD, JD, MPH - Medical Officer
 - Christiane LaBonte, MS - Health Insurance Specialist
 - Karen Nakano, MD - Medical Officer
 - Michael Soracoe, PhD - Analyst
 - Gift Tee, MPH - Director, Division of Practitioner Services
 - Pamela Villanyi, MD - Medical Officer
- He also noted that a number of CMS observers were present for the virtual meeting.
- Doctor Smith welcomed the following Contractor Medical Directors:
 - Janet Lawrence, MD
 - Richard W. Whitten, MD, MBA
- Doctor Smith welcomed the following Member of the CPT Editorial Panel:
 - Jordan Pritzker, MD, MBA - CPT Editorial Panel RUC Member
- Doctor Smith welcomed the following observers:
 - Brian DeBusk, PhD - MedPac Commissioner
 - Bobby Mukkamala, MD - AMA Chair-Elect, Board of Trustees
 - Doctor Mukkamala introduced himself to all RUC participants and expressed his deep interest in participating in the October virtual RUC meeting to better understand the RBRVS process.
- Doctor Smith conveyed the Lobbying Policy:
 - “Lobbying” means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
 - Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
 - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
 - Full lobbying policy found on Collaboration site (Structure and Functions).

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- Doctor Smith shared the following procedural issues for RUC members:
 - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
 - RUC members or alternates sitting at the table may not present or debate for their society.
 - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
- Doctor Smith conveyed the following procedural guidelines related to Voting:
 - Work RVU = 2/3 vote
 - Motions = Majority vote
 - RUC members will vote on all tabs using the voting repository with links provided via email.
 - You will need to have access to a computer or smart phone to submit your vote.
 - If you are unable to vote during the meeting due to technical difficulties, please contact Jorge Belmonte
 - RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
 - We vote on every work RVU, including facilitation reports.
 - If members are going to abstain from voting please notify AMA staff so we may account for all 28 votes.
- Doctor Smith stated the following procedural guidelines related to RUC Ballots:
 - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.
 - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
 - You must enter the work RVU, physician times and reference codes to support your recommendation.
 - Facilitation Committee meetings are set up for 4pm-6pm via Microsoft Teams if necessary.
- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
 - Codes with ≥ 1 million Medicare claims = 75 respondents
 - Codes with Medicare claims between 100,000-999,999 = 50 respondents
 - Codes with $<100,000$ Medicare claims = 30 respondents
 - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

III. Director's Report

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

- Ms. Smith welcomed new AMA staff:
 - Gregory Craig, MS, MPA - Senior Policy Analyst
- Ms. Smith conveyed the following information regarding the new RUC Database application:
 - The new RUC Database is available at <https://rucapp.ama-assn.org>
 - Accessible both online and offline from any device, including smartphones and tablets

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- Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
- Major changes/ new features for the new RUC Database application include:
 - Access the Database both on the internet, as well as download the application to your web browser's cache to enable full offline functionality.
 - The Claims Data tab is updated with more detailed ICD-10 data, Non-Facility utilization data and additional subtabs for imaging and diagnostic services that have Professional Component/ Technical component split.
 - New Billed Together Data tab.
 - The PE Inputs tab is updated with a new aggregate direct PE costs table.
 - Many new advanced search and PE search capabilities.
- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process.
 - The RUC Process webinars may be accessed via the RUC Collaboration home page or click “General Resources” from the left navigation bar and then “New to the RUC” and “RUC Process Webinars & Presentations.”
 - The RUC Process webinars may also be accessed directly via the YouTube link:
<https://www.youtube.com/playlist?list=PLpUAhDfIHfcoS89T0wxivYpHmsYl8fxZp>
- Ms. Smith announced the following for the upcoming January 2021 RUC meeting:
 - The January 2021 RUC meeting will also be virtual.
 - The Relativity Assessment Workgroup, Administrative Subcommittee and the Health Care Professionals Advisory Committee (HCPAC) meetings will be held in early December.
 - RUC Recommendation due date will be Monday, December 14, 2020 at 8am CT, but highly encourage everyone to submit by Friday, December 11th.
 - The January 2021 meeting will also be Doctor Smith's last meeting as Chair.
 - The AMA Board will elect the next RUC Chair, AMA Representative, and Alternate AMA Representative in November 2020. This will be announced after the AMA Board finalizes their decisions.
 - The new RUC Chair's first meeting will be April 2021.

IV. Approval of Minutes from April 2020 RUC Meeting

- The RUC approved the April 2020 RUC meeting minutes as submitted.
- The specialty societies appealed the April 2020 RUC recommendation for Electrophysiologic Evaluation, CPT code 93621 based on a material procedural irregularity. The RUC granted the appeal and the specialty societies re-presented CPT code 93621 as tab 21 in October 2020.

V. CPT Editorial Panel Update (Informational)

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

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- **Panel Meeting Activity in Response to COVID-19 Pandemic**
 - The Panel had six special meetings so far this year for expedited approval of CPT codes for COVID-19 testing.
 - The Panel has approved more than a dozen CPT codes for lab tests.
 - CPT code 99072, from the RUC's Practice Expense Subcommittee, was approved for additional supplies, materials, and clinical staff during a public health emergency.
 - The codes were effective and made available for use no more than three days following the meeting at which the Panel approved them in an effort to make them available as soon as possible.
- **Panel Virtual Meetings**
 - The Panel has had two virtual meetings (May and October) since the April 2020 RUC meeting.
 - At the May 2020 Panel Meeting, the Panel voted on 35 code change applications and 20 of these were voted on the consent agenda.
 - At the October 2020 Panel Meeting, the Panel voted on 66 code change applications, 34 of which were voted on the consent agenda.
- **February 2021 CPT Editorial Panel meeting**
 - The next Panel meeting is February 4-6, 2021.
 - Doug Leahy, MD will be attending the meeting as the RUC representative.
 - The next application submission deadline is November 4, 2020 for the February 2021 Panel meeting, location/format to be determined.
- **CPT/RUC Workgroup on E/M**
 - Work continues to review the rest of the E/M sections other than the office visits.
 - The E/M Workgroup is on track to submit comprehensive CPT Code Change Applications for the rest of the E/M visits by the November 4, 2020 deadline to be reviewed at the February 2021 Panel meeting.
- **Update on Ad Hoc Workgroups**
 - The Image Bundling Workgroup was convened with the charge to address how image bundling is integrated within the CPT code set.
 - The Panel approved a workflow at the October Panel meeting that details the process regarding when image guidance should be bundled into the base procedure.
 - The guidance workflow will be incorporated into the CPT SmartApp.

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

Gift Tee, MPH, Director, Division of Practitioner Services, provided the report of the Centers for Medicare & Medicaid Services (CMS) on their recent Physician Payment Schedule (PPS) initiatives to address the public health emergency for COVID-19.

- **Regulatory Changes to Expand Access During the Public Health Emergency Include:**
 - Medicare Telehealth
 - End Stage Renal Disease (ESRD)
 - Virtual Supervision
 - Virtual Check-in Services
 - Audio-Only Services

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- Remote Physiologic Monitoring
- **CY 2021 PFS Proposed Rule Highlights**
 - On August 3, 2020 CMS issued a Proposed Rule that announced and solicited comments on policy changes for Medicare payments on or after January 1, 2021.
 - CY 2021 Medicare PFS Conversion Factor = \$32.36.
 - Medicare Telehealth and Other Virtual Services.
 - Scope of Practice and Other Related Issues.
 - Teaching Physicians and Residents.
 - Payment for Evaluation and Management (E/M) and Analogous Visits.
 - Opioid Use Disorder/ Substance Use Disorder Provisions.

VII. Contractor Medical Director Update (Informational)

Doctor Janet Lawrence, Medicare Contractor Medical Director (CMD), provided the CMD update covering Twenty-Frist Century Cures: Transparency, Collaboration, and Consistency.

- **Transparency**
 - The Local Coverage Determination (LCD) development process was modified significantly in keeping with the requirements of the 21st Century Cures Act.
 - The LCD was modified to allow stakeholder participation from beginning to end of the process.
 - LCDs must attend an open meeting, regardless if adding or deleting coverage.
- **Collaboration**
 - Within the new process, a CAC may convene in one jurisdiction or multiple, ensuring that the SMEs are representative across jurisdictions.
 - Contractors choose the topics they will collaborate on.
 - A CAC is not always required, the MAC may proceed directly to the open meeting with the draft LCD. The MACs may form workgroups to evaluate data, literature, and experiences. The MACs may choose SMEs and evaluate the testimony to develop the draft LCD.
- **Consistency**
 - The goal is to have consistent coverages across jurisdictions.
 - To achieve the goal, this involves working together throughout the process and following a timeline.

VIII. Washington Update (Informational)

Jennifer McLaughlin, JD, Assistant Director of Federal Affairs, AMA, provided the Washington report focusing on the CY 2021 Proposed Rule, AMA's extensive advocacy efforts during the COVID-19 pandemic, the CARES Act, and Medicare Advance Payment Program Relief.

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- **CY 2021 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Proposed Rule**
 - **Office and Outpatient E/M Visits**
 - AMA strongly supports implementation of CMS' new E/M visit policy effective January 1, 2021.
 - CMS has moved away from its proposal to consolidate the E/M levels and adopted the revised E/M code definitions approved by the CPT Editorial Panel
 - CMS has proposed to adopt revised and increased RVUs for E/M services based on RUC recommendations.
 - AMA supports post-operative visits be valued equivalent to stand alone visits and for CMS to implement the office visit increases into the surgical global payments.
 - AMA recommends CMS postpone implementation of the office visit add-on code.
 - **Payment Cuts Due to Budget Neutrality**
 - AMA strongly recommends CMS waive budget neutrality under the PHE.
 - Postpone implementation of add-on code until better defined by the CPT Editorial Panel.
 - Implement add-on code with no budget neutrality.
 - Phase in budget neutrality cuts over several years.
 - Legislative solutions.
 - **Telehealth and Remote Patient Monitoring**
 - AMA strongly recommends CMS to make permanent several telehealth services, remove barriers to access, continue coverage/payment policies that were put in place during the PHE.
 - AMA concerned over CMS' interpretation of the Remote Patient Monitoring code structure for codes 99457 and 99458.
- **COVID-19 Pandemic**
 - The AMA continues its extensive advocacy efforts during the COVID-19 pandemic through testing, vaccine development, and personal protective equipment (PPE).
- **CARES Act Provide Relief Fund Payments**
 - \$175 billion in relief funds for physicians and other healthcare providers during the COVID-19 pandemic.
 - Funds must be used for lost revenues or increased expenses related to COVID-19.
 - The Department of Health and Human Services (HHS) is disbursing an additional \$20 billion in provider relief funds to physicians who were not previously eligible: psychiatrists, behavioral health providers, and physicians who had received a payment and who may be eligible for an additional payment. Deadline to apply is November 6, 2020.

- **Medicare Advance Payment Program Relief**
 - Postpones recoupment of funds from 120 to 365 days.
 - Reduces the per-claim recoupment from 100 to 25 percent for the first 11 months and then 50 percent for an additional six months.
 - Extends the repayment timeline until September 2022.
 - Lowers interest rates from 10.25 to 4 percent for loans not fully repaid by September 2022.

IX. Anesthesia Overview – Tab 4

Verdi DiSesa, MD, Chair of the Ad Hoc Anesthesia Workgroup, and ASA RUC Advisor, Richard Rosenquist, MD, provided the RUC with an overview of the work of the Anesthesia Workgroup and how to evaluate anesthesia survey results and base unit recommendations.

Background

- In 2016, the RUC Anesthesia Workgroup convened to develop a robust method to evaluate anesthesia base unit recommendations. This had not been done in over a decade
- The RUC Anesthesia Workgroup met multiple times per year (in-person and via conference call) using an iterative approach to develop a final methodology which was approved by the RUC
- This method is to be used for review of anesthesia services utilizing the following components:
 - An Anesthesia Reference Service List (RSL) which was validated through the new Building Block Methodology (BBM)*
 - The BBM will be used as a supplement to magnitude estimation or other RUC methods for code valuation
- The October 2020 RUC meeting is the first opportunity for the Committee to evaluate the results from an anesthesia survey for valuation of anesthesia base units using these new RUC-approved tools

Differences Between RVUs and Base Units

- Unlike RBRVS codes, anesthesia codes have a **single base unit** value rather than separate RVUs for work, PE and PLI
- Base units are whole numbers whereas RVUs extend to the hundredths decimal place
- Medicare maintains a separate conversion factor (CF) for anesthesia services
 - 2021 Proposed Medicare Anesthesia CF: \$19.9631
 - 2021 Proposed Medicare Physician CF: \$32.2605
- Anesthesia Base Unit valuation includes:
 - Pre-anesthesia period work
 - Patient evaluation
 - Equipment, drug and supply preparation
 - Intra-anesthesia differences in intensity and complexity*
 - Post-anesthesia evaluation work

* Time for intra-service anesthesia care is reported separately and paid the same amount per minute for **all types of cases**. This is different than work RVU.

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RUC Approved Evaluation Tools to Assist in Properly Valuing Anesthesia Services

- Anesthesia base unit recommendations are based on survey using a RUC-approved survey instrument, similar to the RBRVS RUC survey instrument
- There are additional RUC approved tools to evaluate the unique aspects of anesthesia services and validate base unit recommendations
- These tools help evaluate base unit recommendations and assist in the unique process of determining appropriate relativity within the Anesthesia RSL
 - BBM and RSL Regression Analysis
 - Post-Induction Period Procedure Anesthesia (PIPPA)

Building Block Method (BBM) Overview

- The anesthesia building block methodology is to be used to **compare relativity among anesthesia services**, it is **NOT** to be used to establish anesthesia base unit value
- The RUC anesthesia survey will continue to be used to establish anesthesia base unit values. The anesthesia building block methodology serves to **validate the recommendations** presented
- For survey recommendations, the BBM value is calculated using recommended time values for each component; this calculated value is known as a “proxy RVU”
- The BBM is a methodology to value anesthesia services in a way that is similar to the codes valued under RBRVS in order to assess the **relativity among anesthesia services**
- The anesthesia service is broken down into five components that correspond to the RBRVS service periods
- Proxy RVU values are calculated for each component based on time recommendations and summed for a total proxy RVU
- The results from the BBM reflect the range of values among anesthesia services relative to each other

RSL Regression Analysis Comparison

- Proxy RVUs will be plotted on the Survey Code RSL Comparison graph
- As these new proxy RVU data points are graphed, the closer a point is to the regression line, the better the proxy RVU and the base unit align
- This will be used to evaluate the **appropriateness of the recommendation** against the RSL services
- Placement on the regression line is not to be used to value anesthesia services
- This regression tool is critical to help evaluate any potential rank order anomalies
- A linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values (“proxy RVUs”) demonstrated that there is a strong ($R^2 = 0.968$) relationship between anesthesia base unit values and the anesthesia building block methodology values (“proxy RVU value”)

Post-Induction Period Procedure Anesthesia (PIPPA)

- PIPPA is a relative **intensity methodology** used by the RUC to validate anesthesia base unit values
 - The post-induction period has varying levels of intensity
 - Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels
- Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another
- PIPPA **does not capture the entire value** of an anesthesia service as intensity and duration during the other anesthesia service periods contribute to the valuation of an anesthesia service
- PIPPA **does not include the difference** in work and intensity of all of the intra-service work
 - Thus, comparing PIPPA intensity alone is insufficient in providing a whole picture of the value of anesthesia services

PIPPA vs IPUT

PIPPA is a measure of intensity that is similar, but not identical to, IPUT

- RUC-Approved Anesthesia RSL
- RUC Tools for the Review of Anesthesia Base Units
- Standard RUC anesthesia survey
- There are additional RUC approved tools to evaluate the unique aspects of anesthesia services and validate base unit recommendations including:
 - BBM and RSL Regression Analysis
 - PIPPA
- These tools help evaluate base unit recommendations and assist in the unique process of determining appropriate relativity within the Anesthesia RSL

X. Relative Value Recommendations for CPT 2022

Exclusion of Left Atrial Appendage – Tab 5

Richard Freeman, MD (STS); Kirk Kanter, MD (STS); Stephen Lahey, MD (AATS); James Levett, MD (STS); Francis Nichols, MD (STS); Jacob Schroder, MD (STS); Joseph Turek, MD (STS); and Prashanath Vallabhajosyula, MD (STS)

In May 2020, the CPT Editorial Panel approved the creation of three new codes to describe open and thoracoscopic left atrial appendage management procedures when performed as stand-alone procedures or in conjunction with other procedures performed via a transthoracic (sternotomy or thoracotomy) approach other than Maze and mitral valve repair/replacement procedures.

33267 Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)

The RUC reviewed the survey results from 73 cardiothoracic surgeons and determined that the survey 25th percentile work RVU of 18.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 45 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time and 30 minutes immediate post-service time, 1-99291 critical visit, 2-99232 subsequent hospital care visits, 1-99238 discharge visit, and 1-99213 office visit. The RUC noted that the additional 5 minutes of pre-

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service time is necessary to discuss the risk of adverse embolic phenomena and/or anti-coagulation events with the family and patient and that this is standard for open codes in this family. However, the RUC noted that these discussions would be unnecessary for the endoscopic code 33269 in this family given the nature of the procedure.

The RUC compared CPT code 33267 to the top key reference code 32666 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* (work RVU = 14.50 75 minutes intra-service time and 332 minutes total time) and noted both the lower total time associated with CPT code 32666 as well as 91% of survey respondents that selected this key reference code indicated that the work associated with CPT code 33267 is either somewhat or much more intense/complex than the work associated with CPT code 32666. To further support a work RVU of 18.50, the RUC compared the survey code to CPT code 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)* (work RVU=18.00, intra-service time of 90 minutes, total time of 367 minutes) and noted that both services involve identical intra-service time, whereas the survey code involves 25 more minutes of total time. **The RUC recommends a work RVU of 18.50 for CPT code 33267.**

33268 *Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)*

The RUC reviewed survey results from 93 cardiothoracic surgeons and determined that a direct work RVU crosswalk to CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU = 2.50 and 20 minutes total time) correctly reflects the physician work necessary to perform this service. The RUC recommends 20 minutes intra-service time for CPT code 33268.

The specialty societies indicated, and the RUC agreed that the survey 25th percentile work RVU of 5.15 would overvalue this add-on service. Therefore, the RUC determined for CPT code 33268 to have its work value crosswalked to CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service time of 20 minutes), because they both have the same intra-service and total time – both services also involve the same overall amount of physician work. The RUC noted that the intensity of code 33268 compares favorably to the intensity of key reference codes 32507 *Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)* (work RVU = 3.00, 30 minutes total time) and 34714 *Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 5.25, 52 minutes total time). **The RUC recommends a work RVU of 2.50 for CPT code 33268.**

33269 *Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)*

The RUC reviewed the survey results from 77 cardiothoracic surgeons and determined that a direct work RVU crosswalk to CPT code 33020 *Pericardiotomy for removal of clot or foreign body (primary procedure)* (work RVU = 14.31, 60 minutes intra-service time and 321 minutes total time.) accurately reflects the physician work necessary to perform this service. The RUC recommends 42 minutes pre-evaluation time, 15 minutes pre-positioning time, and 15 minutes pre-scrub/dress/wait time, 65 minutes intra-service time, and 30 minutes immediate post-service time.

The RUC determined that this crosswalk was appropriate given the similarity in physician work intensity and total time. The RUC noted that the survey 25th percentile work RVU of 18.00 was too high and would not represent a large enough difference with the open procedure described in 33267. For additional support, the RUC referenced top key reference service 32666 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* (work RVU = 14.50, 75 minutes intra-service time and 332 minutes total time). In their intensity/complexity comparison, the survey respondents that selected this key reference code indicated that the survey code was more or somewhat more complex than 32666 for all of the intensity/complexity measures except the physical effort required; thus 33269 is appropriately more intense but has a slightly lower work RVU. **The RUC recommends a work RVU of 14.31 for CPT code 33269.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the standard 90-day global inputs for CPT code 33267 and 33269 and made no changes to the societies' request. CPT code 33268 is a ZZZ global code and has no practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology

CPT codes 33267, 33268, 33269 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Harvest of Upper Extremity Artery, Endoscopic and Open – Tab 6

Richard Freeman, MD (STS); Kirk Kanter, MD (STS); Stephen Lahey, MD (AATS); James Levett, MD (STS); Francis Nichols, MD (STS); Jacob Schroder, MD (STS); Joseph Turek, MD (STS); and Prashanath Vallabhajosyula, MD (STS)

Facilitation Committee #1

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

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

The RUC reviewed the specialty societies' recommended work RVU of the survey 25th percentile of 5.63 from 39 cardiothoracic surgeons and concurred that the survey respondents overestimated the work involved in performing this service. The RUC agreed that a direct work RVU crosswalk to CPT code 33987 *Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)* (work RVU= 4.04, intra-service and total time of 45 minutes) was appropriate, noting that both codes involve an identical amount of physician time and work to perform. The RUC recommends interim intra-service time of 45 minutes for CPT code 33509.

The specialty societies explained the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their National Provider Identifier (NPI) number. It was noted that it is often a Nurse Practitioner (NP) or Physician's Assistant (PA) who performs the harvest procedure. The RUC noted that NPs and PAs were not included in the survey sample and therefore it would be appropriate to resurvey this service for the January 2021 RUC meeting to include these providers who are potentially the dominant providers. **The RUC recommends an interim work RVU of 4.04 for CPT code 33509.**

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35600 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open

The RUC rejected the specialty societies' initial recommendation to maintain the current work RVU of 4.94 for CPT code 35600, noting that the IWP/PUT associated with this work RVU value would be higher than the CABG procedure itself. The RUC agreed that a direct work RVU crosswalk to CPT code 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)* (work RVU= 3.73, intra-service time of 40 minutes, total time of 42 minutes) is appropriate, noting that both codes require similar intra-service times and identical total time and an identical amount of physician work. The RUC recommends interim time of 42 minutes intra-service.

The specialty societies explained that the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual who performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI. It was noted that it is often a Nurse Practitioner (NP) or Physician's Assistant (PA) who performs the harvest procedure. The RUC noted that NPs and PAs were not included in the survey sample and therefore it would be appropriate to resurvey this service for the next meeting to include the providers that are potentially the dominant providers. **The RUC recommends an interim work RVU of 3.73 for CPT code 35600.**

Practice Expense

CPT codes 33509 and 35600 are typically performed in the facility setting and do not have any direct practice expense inputs.

Modifier-51 Exempt Status

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

New Technology

CPT codes 35600 and 33509 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Per-Oral Endoscopic Myotomy (POEM) – Tab 7

R. Bruce Cameron, MD (ACG); Patricia Garcia, MD (AGA); Seth A. Gross, MD (ASGE); Vivek Kaul, MD (ASGE); Stephen Lahey, MD (AATS); James Levett, MD (STS); Shivan Mehta, MD (AGA); Francis Nichols, MD (STS) and Ketan Sheth, MD (SAGES)

In May 2020, the CPT Editorial Panel created new code 43497 *Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])* to describe a Per-Oral Endoscopic Myotomy (POEM), which involves the visualization and dissection of the esophageal muscle layers via an endoscope to treat esophageal motility disorders such as achalasia. This procedure accomplishes a comparable myotomy to what traditional open and laparoscopic myotomy (Heller) accomplishes. POEM utilizes an endoscope and specially designed dissecting, cutting, and cauterizing instruments to create a long submucosal tunnel beginning in the mid-esophagus and extending several centimeters into the cardia.

43497 Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])

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The RUC reviewed the survey results from 119 physicians and determined that the survey 25th percentile work RVU of 15.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time and 50 minutes immediate post-service time, 0.5-99238 discharge visit, and 2-99213 office visits. The RUC discussed the addition of 20 minutes of immediate post-service time to the initial value of 30 minutes of immediate post-service time, for a final recommendation of 50 minutes of immediate post-service time. The societies explained that it is typical for the performing physician to check in on the patient following the procedure; however, given CMS rules prohibiting an observation visit during hospital stays of less than 24 hours (as would be the case for CPT code 43497), listing such a visit would be improper. Therefore, the societies included this observation time in the immediate post-service time.

The RUC compared CPT code 43497 to the top two key reference services: CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU = 22.10 and 150 minutes intra-service time) and CPT code 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and 60 minutes intra-service time). The RUC noted 43279 requires more physician time and work to perform, yet similar intensity, thus is appropriately valued more than CPT code 43497. CPT code 43180 requires much less physician time, work and intensity, thus is appropriately valued less than CPT code 43497. Additionally, 74% of the survey respondents that selected key reference code 43180 indicated overall, 43497 was more intense and complex to perform than 43180.

For additional support the RUC referenced MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00- and 90-minutes intra-service time) and 60500 *Parathyroideectomy or exploration of parathyroid(s)* (work RVU = 15.60 and 120 minutes intra-service time). **The RUC recommends a work RVU of 15.50 for CPT code 43497.**

Practice Expense

The Practice Expense Subcommittee reviewed the standard 90-day global inputs and determined that the standard exam table is typical for postoperative office visits. Thus, EF023 *table, exam* was added to the equipment inputs and EF031 *table, power* was removed. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology

CPT code 43497 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Retinal Detachment Prophylaxis – Tab 8

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

CPT code 67145 was identified in October 2019 as Harvard Valued utilization over 30,000. In January 2020, the RUC agreed with the specialty societies and recommended that CPT code 67145 as well as its parent code 67141 be referred to CPT for a descriptor and global period change. The codes were edited to remove the reference to “1 or more sessions” so that the services may be valued as a 010-day procedure versus the current 090-day global. At the May 2020 CPT Editorial Panel meeting, the Panel approved revision of the two codes to remove “1 or more sessions” from the descriptors and deletion of the Eye and Ocular Adnexa Prophylaxis guidelines.

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67141 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy

CPT code 67141 describes cryotherapy of a retinal tear typically in an adult without the presence of a retinal detachment and is typically performed in a non-facility setting with local anesthesia. The RUC reviewed the survey results from 58 ophthalmologists and retina specialists and determined that a work RVU of 2.53 accurately reflects the physician work necessary for this service. Acknowledging that this falls considerably below the survey 25th percentile and below any RVU indicated by the survey respondents, the RUC determined that a direct work RVU crosswalk to CPT code 32552 *Removal of indwelling tunneled pleural catheter with cuff* (work RVU = 2.53, 15 minutes intra-service time and 82 minutes total time) would be appropriate and supportive of the valuation.

The RUC recommends 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 15 minutes intra-service time, 5 minutes immediate post-service time and two 99213 office visits. The RUC acknowledged that the median survey intra-service time of 15 minutes is a substantial reduction compared to the current value, however, CPT code 67141 is Harvard valued and thus has never been surveyed and reviewed by the RUC. The RUC reduced the pre-service evaluation time from the pre-service package time of 17 minutes to 5 minutes to account for overlap of work with the same-day Evaluation and Management (E/M) visit. It is typical for the patient to be seen by a provider (ophthalmologist or optometrist) first then referred to a retina specialist. Most patients are referred for floaters and floaters not for a tear, and it is during the E/M visit that the tear is ascertained, treatment is recommended and ultimately performed. In addition, the pre-service positioning time was reduced from the median survey time of 5 minutes to 1 minute (package time). The pre-service scrub/dress/wait time of 5 minutes was supported by the survey and includes administration of the topical and subconjunctival anesthesia and checking the probe to ensure adequate freezing. The survey immediate post-service time of 5 minutes to monitor and instruct the patient on postoperative care, prepare an operative report, discuss symptoms of a retinal detachment and contact the referring physician is recommended.

The RUC supports the survey result of two 99213 postoperative visits, a decrease from the current number of three 99213 visits. Both visits, typically 1 day and approximately 1 week after the procedure respectively, entail a complete dilated examination to assess early response to therapy. Both visits are critical because timely intervention is required if a detachment develops so that more definitive treatment can occur before the macula detaches with an associated loss of central vision. Progression to a retinal detachment with accumulation of subretinal fluid, when it occurs, typically happens within days of the original presentation. This can occur if the tear extends beyond the boundary of the performed treatment or if additional retinal tears develop, which is not uncommon. The risk of the tear extending beyond the treatment is greatest in the first day or two after treatment since the adhesion around the tear takes time to develop. The risk of finding additional tears is typically greater at the one-week visit. Urgent intervention with a more invasive procedure (separately reported) to prevent progression is necessary, as delay of only one day may lead to macular detachment, which is associated with a significantly poorer visual outcome. Therefore, the entire peripheral retina must be examined the day after the treatment and again within another week.

CPT code 67141 has changed from a 090-day global to a 010-day global procedure and was surveyed as such. However, there are no 15-minute 010-day global procedures with two 99213 postoperative visits. As a result, there were no 010-day global codes valued in the past 10 years with an intra-service time of 15 minutes and similar total times that were eligible for crosswalk, nor were there any with a high enough work value to result in a positive IPUT. Including codes valued up to 15 years ago, the RUC recommends CPT code 32552 as the direct work value crosswalk code. For further support, the RUC compared CPT code 67141 to the top key reference code 67227 *Destruction of extensive or progressive* CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy (work RVU = 3.50, 11 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time) and noted that the overall intensity and complexity for the survey code is higher than for the reference code as justified by the shorter intra-service time which is half that of the reference code.

Finally, the RUC referenced MPC codes 11443 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm* (work RVU = 2.34, 20 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time) and 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU = 2.62, 15 minutes pre-service time, 25 minutes intra-service time and 5 minutes immediate post-service time) for additional support. The RUC concluded that CPT code 67141 should be valued based on a direct work RVU crosswalk to CPT code 32552 which falls below the survey lowest response and is appropriately bracketed by the multi-specialty points of comparison codes. **The RUC recommends a work RVU of 2.53 for CPT code 67141.**

67145 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation

The two codes in this family, CPT codes 67141 and 67145, describe two different methods of treating the same pathology. CPT code 67145 describes laser photocoagulation of a retinal tear typically in an adult without the presence of a retinal detachment. It is typically performed in a non-facility with local anesthesia. The RUC reviewed the survey results from 66 ophthalmologists and retina specialists and determined that a work RVU of 2.53 accurately reflects the physician work necessary for this service. Acknowledging that this falls considerably below the survey 25th percentile and below the lowest survey response, the RUC determined that a direct work RVU crosswalk to CPT code 32552 *Removal of indwelling tunneled pleural catheter with cuff* (work RVU = 2.53, 15 minutes intra-service time and 82 minutes total time) would be appropriate and supportive of the valuation.

The RUC recommends 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 3 minutes of pre-service scrub/dress/wait time, 16 minutes intra-service time, 5 minutes immediate post-service time and two 99213 office visits. CPT code 67145 is Harvard valued and thus has never been surveyed and reviewed by the RUC and therefore times are not valid for comparison. As with the parent code, the RUC decreased the pre-service evaluation time to 5 minutes given concerns with overlap of work with the same day E/M visit. The RUC also noted that performance of both procedures on the same day would be extremely uncommon and there is currently a CCI edit precluding reporting of both procedures together.

The RUC supports the survey result of two 99213 postoperative visits, a decrease from the current number of three 99213 visits. Both visits, typically 1 day and approximately 1 week after the procedure, entail a complete dilated examination to assess early response to therapy. Both visits are critical because timely intervention is required if a detachment develops so that more definitive treatment can occur before the macula detaches. Progression to a retinal detachment with accumulation of subretinal fluid, when it occurs, typically happens within days of the original presentation. This can occur if the tear extends beyond the boundary of the performed treatment or if additional retinal tears develop, which is not uncommon. The risk of the tear extending beyond the treatment is greatest in the first day or two after treatment since the adhesion around the tear takes time to develop. The risk of finding additional tears is typically greater at the one-week visit. Urgent intervention with a more invasive procedure to prevent progression is necessary, as delay of only a day may lead to macular detachment, which is associated with a significantly poorer visual outcome. Therefore, the entire peripheral retina must be examined the day after the treatment and again within another week.

Both codes in the family changed from 090-day to 010-day global periods. As with CPT code 67141, there are no recent 15- or 16-minute 010-day global procedures with two postoperative visits, making it impossible to find a crosswalk with a similar intra-service time and a work value resulting in a positive IWP/PUT. Going back to 2008, there was support for a value of 2.53 RVUs from CPT code 32552 as a crosswalk code. This is identical to the recommendation for CPT code 67141 as the amount of physician work of the two procedures is essentially the same.

The RUC compared CPT code 67145 to the top key reference code 67228 *Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation* (work RVU = 4.39, 23 minutes pre-service time, 25 minutes intra-service time and 10 minutes immediate post-service time) and noted that the overall intensity and complexity for the survey code is higher and the intra-service time is ten minutes less than for the reference code. To further justify a work value of 2.53, the RUC also referenced key MPC codes 11443 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm* (work RVU = 2.34, 20 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time) and 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU = 2.62, 15 minutes pre-service time, 25 minutes intra-service time and 5 minutes immediate post-service time) and noted that these multi-specialty points of comparison codes appropriately bracket the survey code.

The RUC concluded that CPT code 67145 should be valued based on a direct work RVU crosswalk to CPT code 32552 which falls below the lowest survey response. **The RUC recommends a work RVU of 2.53 for CPT code 67145.**

Practice Expense

The Practice Expense Subcommittee accepted the spreadsheet for CPT codes 67141 and 67145 as submitted, including reductions for changing from 090-day to 010-day global period and eliminating any overlap with the ophthalmology office visits. No modifications were made. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Office Visits Included in Codes with a Surgical Global Period

The RUC strongly believes that it is appropriate to apply the increased valuation of the office visits to the visits incorporated in the surgical global packages. However, the Centers for Medicare & Medicaid Services (CMS) proposes not to apply the office visit increases to the visits bundled into global surgery payment. An example of why this policy is flawed was raised during discussion of CPT code 67141. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and is in alignment with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes are being valued too low considering that office visits for the surgical global period are not going to change. The 99213-office visit in 2021 will be valued at 1.30 RVUs, therefore, the two office visits will be valued higher than this code. It is disadvantageous to the eye surgeons and an example of the why the policy from CMS is flawed. The Agency implies that the physician work for office visits are not the same when performed in a surgical global period. As stated in the RUC comment letter to CMS on the CY 2021 Proposed Rule, **The RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard. The RUC urges CMS to apply the office visit increases to the office visits included in surgical global payment, as it has done historically.**

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Do Not Use to Validate for Physician Work

The RUC agreed that CPT codes 67141 and 67145 should be labeled in the RUC database with a flag that they should not be used to validate physician work. These services are valued below the lowest survey response and would not be appropriate to compare the relativity for other codes particularly noting the absence of eligible crosswalk codes with 010-day global and two 99213 visits as supported by the survey.

Work Neutrality

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

Orthoptic Training – Tab 9

Charles Fitzpatrick, OD (AOA); David B. Glasser, MD (AAO) and Ankoor Shah, MD (AAO)

This service was identified in October 2019 as Harvard Valued utilization over 30,000. In January 2020, the RUC recommended that CPT code 92065 be referred to CPT May 2020 for a descriptor edit and possible creation of separate codes. This service, with an amorphous “and/or” connector, could be two different codes given their different patient populations and techniques used for the treatment. At the May 2020 CPT Editorial Panel meeting, the Panel approved revision of the code to remove “and/or pleoptic” and “with continuing medical direction and evaluation” from the descriptor.

At the October 2020 RUC meeting, based on pre-facilitation by the RUC, the specialty societies indicated their intent to take this code back to the CPT Editorial Panel to create two separate codes. The societies requested referral to CPT and plan to submit a new code change application for the February 2021 CPT Editorial Panel meeting. During review and analysis of the survey, it became evident that this service is delivered in two different ways. Because of this, it is necessary to create two codes to delineate when the training is provided directly by the provider and when it is provided by a technician under the supervision of the provider. Doing so will ensure more accurate valuation of both work and practice expense associated with this service. The RUC supports creation of a companion code and concurs that code 92065 should be referred to the February 2021 CPT Editorial Panel meeting for *CPT 2023*. **The RUC recommends CPT code 92065 be referred to CPT.**

Cardiac Catheterization for Congenital Defects – Tab 10

Sergio Bartakian, MD (SCAI); Steven E. Krug, MD (AAP); Edward Toggart, MD (SCAI); Edward Tuohy, MD (ACC); Thad Waites, MD (ACC) and Richard Wright, MD (ACC)
Facilitation Committee #3

In May 2020, the CPT Editorial Panel replaced a family of four cardiac catheterization codes with five new codes to describe cardiac catheterization for congenital cardiac defect(s). In addition, the Panel replaced two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects.

Compelling Evidence

The RUC reviewed and agreed that there is compelling evidence based on a change in the patient population and a change in technology. The specialty societies noted and the RUC agreed that the vast majority of diagnostic catheter studies were performed in children who were healthier with simpler cardiac defects when the previous code structure was last valued in 1997; children with more significant cardiac defects had no treatment options, so catheterization was not warranted. Over the past 23 years, as result of improvements in both technique and technology, the specialty has evolved and now performs a substantially larger number of more complex diagnostic evaluations to guide more complex interventional CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

procedures, and the typical patient is now a more complex patient requiring more pathology. The specialties noted that one of the whitepapers that they provided by Nicholson et al. confirms that these procedures were unable to be previously accomplished on the current typical patient with earlier technology/techniques. The specialties provided additional literature to further demonstrate the changes in congenital catheterization over the past two decades.

The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

93593 Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 3.99 for CPT code 93593. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time and 45 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent and the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which also adds post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The specialty noted and the RUC agreed that the existing codes for cardiac catheterization for congenital heart disease have inappropriately low IPUTs that are not in line with the other cardiac catheterization codes that are for patients without congenital heart disease (codes 93452-93461).

The RUC and the specialty societies discussed how deleted code 93530 was previously the only "right heart only" catheterization code designed to capture all possible pathologies for patients with congenital heart disease. This work is now being segmented into 93593 for patients with simple defects, defined in CPT as having normal native connections, and 93594 for the more complex patients with abnormal native connections. The RUC concurred that this change in code structure is one of several reasons why comparing the 1997 physician times for 93530 to both 93593 and 93594 is precarious at best. The RUC also noted that when deleted code 93530 was last evaluated by the RUC and CMS in 1997, both the RUC and CMS evaluated physician time with much less rigor and the valuation process has greatly evolved and become more refined. Correspondingly, deleted code 93530 has an inappropriately low IPUT of 0.0206, which implies that the 1997 times are overstated relative to the current work RVU. Separately, the RUC also noted that 0.25 work RVUs and 10 minutes of pre-service time were systematically removed from the deleted code in 2017 when moderate sedation was unbundled from all services following the deletion of CPT Appendix G. As 93530 is typically performed on an infant under *general anesthesia*, the specialty noted and the RUC agreed that including 93530 in the moderate sedation unbundling initiative was inappropriate, and had an unwarranted downward effect on the work RVUs currently credited to the code. Furthermore, the times captured in surveys in 1997 only reflected a small number of specialists who had

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adequate experience to provide reliable information on the procedure, a reflection of the nascent nature of the specialty 23 years ago.

To justify a value of 3.99, the RUC compared the survey code to CPT code 49422 *Removal of tunneled intraperitoneal catheter* (work RVU= 4.00, intra-service time of 45 minutes, total time of 111 minutes) and noted that both services involve an identical amount of intra-service time and a similar overall amount of physician work. The RUC also compared the survey code to MPC code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes, total time of 116 minutes) and noted that both services involve identical intra-service time and the survey code at 3.99 would be appropriately valued to this reference service. **The RUC recommends a work RVU of 3.99 for CPT code 93593.**

93594 Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections

The RUC reviewed the survey results from 45 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 6.10 for CPT code 93594. The RUC recommends 46 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 60 minutes of intra-service time and 48 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent and the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC and the specialty societies discussed how deleted code 93530 was previously the only right heart only catheterization code designed to capture all possible pathologies for patients with congenital heart disease. This work is now being segmented into 93593 for patients with simple defects, defined in CPT as having normal native connections, and 93594 for the more complex patients with abnormal native connections. The RUC concurred that this change in code structure is one of several reasons why comparing the 1997 physician times for 93530 to both 93593 and 93594 is precarious at best. The RUC also noted that when deleted code 93530 was last evaluated by the RUC and CMS in 1997, both the RUC and CMS evaluated physician time with much less rigor and the valuation process has greatly evolved and become more refined. Correspondingly, deleted code 93530 has an inappropriately low IWP/PUT of 0.0206, which implies that the 1997 times are overstated relative to the current work RVU. Separately, the RUC also noted that 0.25 work RVUs and 10 minutes of pre-service time were systematically removed from the deleted code in 2017 when moderate sedation was unbundled from all services following the deletion of CPT Appendix G. As 93530 is typically performed on an infant under *general anesthesia*, the specialty noted and the RUC agreed that including 93530 in the moderate sedation unbundling initiative was inappropriate, and had an unwarranted downward effect on the work RVUs currently credited to the code. Furthermore, the times captured in surveys in 1997 only reflected a small number of specialists who had adequate experience to provide reliable information on the procedure, a reflection of the nascent nature of the specialty 23 years ago.

To justify a value of 6.10, the RUC compared the survey code to CPT code 36217 *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family* (work RVU= 6.29, intra-service time of 60 minutes, total time of 111 minutes) and noted that both services involve identical intra-service time and a similar overall amount of physician work. The RUC also compared the survey code to CPT code 20245 *Biopsy, bone, open; deep (eg,*

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humeral shaft, ischium, femoral shaft) (work RVU=6.00, intra-service time of 60 minutes, total time of 160 minutes) and noted that although both services have identical intra-service time, the survey code involves 10 more minutes of total time, supporting the somewhat higher work value. **The RUC recommends a work RVU of 6.10 for CPT code 93594.**

93595 Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 6.00 for CPT code 93595. The RUC recommends 46 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 48 minutes of intra-service time and 46 minutes of immediate post-service time. The specialty societies noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

CPT code 93595 describes a left heart catheterization procedure in patients with congenital heart and vascular defects. In addition to left heart obstructive lesions such as aortic valve stenosis and coarctation of the aorta, a left heart catheterization is often needed for evaluation of patients with pulmonary blood flow originating from the aorta; those with major aorto-pulmonary collateral arteries or, major aortopulmonary collateral arteries (MAPCAs), for example. Such patients typically have numerous vascular connections from the aorta to supply the pulmonary blood flow in a secondary vascular tree, either in addition to, or as replacement for the native pulmonary arterial tree. These procedures require a significantly greater level of diagnostic evaluation, catheter and wire manipulation, and angiography to identify each vessel for surgical planning than previously afforded with the non-congenital diagnostic codes.

The RUC noted that 93595 is typically somewhat more intense to perform than 93594, justifying a somewhat higher assigned physician work intensity. For 93595, the physician typically accesses the femoral artery after which all of them connect to the aorta; there is no variability with this for the most part. For a normal connection patient, it will be straightforward. Risk of arterial catheterization is always high due to risks of stroke, bleeding into the brain for infants on heparin, femoral artery injury for infants. For an abnormal connection patient, things get more complicated because doctors are now also talking about crossing arterial shunts or the PDA to evaluate the pulmonary arteries, or evaluating other vascular structures like MAPCAs, which can be multiple. Although the overall structures evaluated are still fewer than from a right heart catheterization (93594), when assessing the pulmonary arteries across shunts or a PDA, this is not typically well tolerated. These shunts are 3 or 3.5mm in diameter with a catheter being ~1.5mm, the procedure involves blocking roughly 50 percent or more of the entire blood flow to the lungs. Due to this, the physician work intensity is very high.

To justify a value of 6.00, the RUC compared the survey code to CPT code 93453 *Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU=5.99, intra-service time of 45 minutes, total time of 113 minutes) and noted that the survey code involves similar intra-service time and more total time, and similar amount of physician work. The RUC also compared the survey code to CPT code 37248 *Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same*

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vein; initial vein (work RVU= 6.00, intra-service time of 50 minutes, total time of 109 minutes) and noted that the survey code involves similar intra-service time and more total time, and a similar total amount of physician work. **The RUC recommends a work RVU of 6.00 for CPT code 93595.**

93596 Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 7.91 for CPT code 93596. The RUC recommends 50 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 60 minutes of intra-service time and 53 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

To justify a value of 7.91 the RUC compared the survey code to CPT code 93461 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization...* (work RVU=7.85, intra-service time of 60 minutes, total time of 143 minutes) and noted both services involve identical intra-service times whereas the survey code involves more total time. The RUC also compared the survey code to CPT code 52356 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU= 8.00, intra-service time of 60 minutes, total time of 133 minutes) and noted both services involve identical intra-service times and a similar overall amount of physician work. **The RUC recommends a work RVU of 7.91 for CPT code 93596.**

93597 Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends the current work RVU of 9.99 for CPT code 93597. The RUC recommends 55 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 83 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

To justify a value of 9.99, the RUC compared the survey code to CPT code 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch* (work RVU= 9.85, intra-service time of 68 minutes, total time of 127 minutes) and noted that, although the survey code involves more intra-service and total time, that is offset by it being somewhat less intense to perform. The RUC agreed both services should be valued similarly. **The RUC recommends a work RVU of 9.99 for CPT code 93597.**

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+93598 Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 46 interventional and pediatric interventional cardiologists and recommends 20 minutes of intra-service time. The RUC reviewed the survey 25th percentile work RVU of 2.00 and agreed that this value overstates the amount of physician work involved. The RUC agreed that a direct work value crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service time= 20 min) is appropriate, as both services involve an identical amount of physician work and time and therefore, should be valued the same. The RUC also compared the survey code to CPT code 20931 *Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)* (work RVU= 1.81, intra-service time of 20 minutes) and noted that both services involve identical intra-service times, though the survey code is slightly less intense to perform. **The RUC recommends a work RVU of 1.75 for CPT code 93598.**

Practice Expense

These services are facility-only and have no direct practice inputs. **The RUC recommends no direct practice inputs for CPT codes 93593-93598.**

New Technology/New Service

The RUC recommends that 93593-93598 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

3D Imaging of Cardiac Structures – Tab 11

Michael Main, MD (ASE); Geoff Rose, MD (ASE); Edward Tuohy, MD (ACC); Thad Waites, MD (ACC) and Richard Wright, MD (ACC)

In May 2020, the CPT Editorial Panel created one new add-on code to describe the 3D echocardiographic imaging and postprocessing during transesophageal or transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structure(s).

93319 3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)

The RUC reviewed the survey results from 108 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 0.50 for CPT code 93319. The RUC recommends 20 minutes of intra-service time. The specialties note that this service is distinct from existing 3D rendering imaging codes as it is all active physician work where the physician themselves are performing the work of image acquisition – this service does not involve post processing on a separate workstation.

The RUC compared the survey code to top key reference code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU= 0.38, intra-service time of 15 minutes) and noted that the survey code has 5 more minutes of intra-service time and 88 percent of the survey respondents that selected this key reference code indicate the survey code was more intense and complex to perform. For additional support, the RUC referenced 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)* (work RVU= 0.61, intra-service time of 20 minutes) and second key reference code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* (work RVU=0.85, intra-service time of 15 minutes). **The RUC recommends a work RVU of 0.50 for CPT code 93319.**

Practice Expense

The Practice Expense Subcommittee adjusted the clinical activity times for CA030 and CA032 to reflect only 3 total minutes of clinical staff time to QC images and scan exam documents into the PACS as the physician is performing the procedure. Also, EF018 *stretcher* was removed from the equipment inputs as it is not typically required. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Service

The RUC recommends that 93319 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Prolonged Services – Tab 12

Megan Adamson, MD (AAFP); Sherry Barron-Seabrook, MD (AACAP); Audrey K. Chun, MD (AGS); Steven E. Krug, MD (AAP); Joshua Liao, MD (ACP); Phillip Rodgers, MD (AAHPM); Fredrica Smith, MD (ACRh); Marianna Spanaki, MD (AAN); Kai-ping Wang, MD (AACAP) and Tanvir Hussain, MD (ACP)

In September 2019, the CPT Editorial Panel added a new table to the CPT introductory language for Prolonged Services that illustrates the elements of all existing and new prolonged care services and how they are to be reported. This clarification was in response to a request of CMS in the July 2019 Proposed Rule for the 2020 Medicare Physician Payment Schedule. CMS also stated that the valuation of CPT codes 99358 and 99359 be reviewed.

In the Final Rule for 2020, CMS indicated:

Since Medicare began separately paying for CPT codes 99358-99359 in 2017 under the PFS, their PFS utilization has increased more than ten-fold from approximately 10,000 claim lines in 2016 to approximately 126,000 claim lines in 2018. While this remains a small percentage of E/M visit claims, utilization may further increase once all office/outpatient E/M visits can be reported based on time alone and new activities such as documenting clinical information are explicitly counted as qualifying time. We continue to believe that the new CPT prefatory language on these codes is difficult to follow and interpret. For example, it states, “for prolonged time without direct patient contact on the date of office or other outpatient services, use 99417. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to-face encounter.” But for CPT code 99417 it states not to report 99417 in conjunction with 99358, 99359 which could mean not to report 99358-99359 if 99417 is reported, even on a separate day. Additionally, CPT would allow reporting at the midpoint of time for CPT codes 99358-99359 but not 99417, and these codes have discrepant time increments (one hour for CPT codes 99358-9 reportable after the midpoint, and 15 minutes for CPT code 99417 not reportable after the midpoint). Under the new CPT framework allowing the use of time to select visit level and the new list of qualifying activities, there is a new Medicare program vulnerability and potential increased beneficiary cost sharing associated with the inability to assess what visit(s) prolonged service codes reported on a date other than the visit are associated with and, accordingly, to assess whether the prolonged time was reasonable and necessary. If more than one visit was furnished (for example, if a beneficiary has an inpatient visit or another outpatient visit by the same practitioner within a wide time range of a given office/outpatient visit), it would not be clear which visit the prolonged time reported under CPT codes 99358-99359 is associated with for evaluating medical necessity and increments of time in relation to the base/companion code.

We continue to believe it would be administratively simpler and improve payment accuracy and program integrity to have only a single add-on code specific to prolonged office/outpatient E/M visits that is clearly linked to the companion E/M office/outpatient visit code. We believe that under the new coding framework, CPT codes 99358-99359 are potentially misvalued, need to be revised for clarity and present new program integrity challenges. Therefore, we are finalizing our proposal that CPT codes 99358-99359 will not be payable in association with office/outpatient E/M visits beginning in CY 2021. We will consider future changes made to these codes by the CPT Editorial Panel or the RUC for possible future rulemaking. We note that a number of other codes such as CCM, TCM, and other care management codes may be used to report time spent outside the direct patient contact on dates other than the office/outpatient visit, if the reporting requirements for those services are met. While these care management codes are not identical to the prolonged visit codes, they can be used to report a number of similar activities.

In January 2020, no specialty societies indicated an interest to survey these services. The American Academy of Family Physicians indicated that they interpreted the CPT changes as editorial only. In the Final Rule, CMS had ongoing concern and confusion with 99358 and 99359 and their guidelines, even in the wake of the CPT Editorial Panel’s action in September 2019. Further, the specialty societies would like to address questions and concerns that CMS has in this regard, so these prolonged services codes may be appropriately used in conjunction with the Evaluation and Management (E/M) office visit codes in CY CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

2021 and beyond, after needed CPT clarification. The specialty societies recommended that these services be referred to CPT prior to a resurvey. The RUC discussed this issue and recommended that CPT codes 99358 and 99359 be referred to the May 2020 CPT Editorial Panel to clarify how these services may be reported with other E/M services.

In May 2020, the CPT Editorial Panel revised the existing Prolonged Services section to remove references to typical times to reflect the new total time definition for office visits.

At the October 2020 RUC meeting, the specialty societies indicated that the recent changes at CPT were editorial, clarifying when the codes should be reported rather than the work inherent in the codes themselves, and the descriptors were unchanged. The RUC was concerned that CPT codes were identified as potentially misvalued by CMS and 99358 and 99359 have not been surveyed since 1993. The specialty societies requested additional time for physicians to gain experience reporting the prolonged services codes with the revised office visit codes prior to surveying 99358 and 99359.

The RUC noted that the joint CPT/RUC Workgroup on E/M is continuing its work of revising the E/M code set and prolonged services 99358 and 99359 may be part of and/or affected by these revisions. The CPT/RUC Workgroup on E/M intends to examine coding guideline changes and code revisions for the remaining E/M services at the February 2021 CPT meeting and the RUC will review these recommendations at its April 2021 meeting. **The RUC recommends that CPT codes 99358 and 99359 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 cycle and the 2023 Medicare Physician Payment Schedule.**

Anesthesia for Cardiac Electrophysiologic Procedures – Tab 13

Neal Cohen, MD (ASA); Gordon Morewood, MD, MBA (ASA) and Richard Rosenquist, MD (ASA)

In October 2016, the RUC identified 00537 *Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation* via the high volume growth screen for services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2009 through 2014. In October 2019, the RUC reviewed this service and recommended survey for the October 2020 meeting.

Compelling Evidence

The specialty society indicated, and the RUC agreed with the compelling evidence that there has been a change in patient population and change in technique since the previous survey in 2000.

Change in patient population

When this code was last surveyed in 2000, the vignette described a 32-year-old man undergoing an electrophysiology procedure for identification of Wolff-Parkinson-White (WPW) syndrome pathway and ablation. The underlying procedure for which 00537 is currently typically provided is CPT code 93656 *Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation*. The vignette used in the current survey reflects the change in the typical patient and the underlying procedure being performed: a 62-year-old man with recurrent atrial fibrillation having electrophysiologic studies with induction or attempted induction of arterial fibrillation and then intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation (PVI). For the previous survey and vignette, the patient was described as otherwise healthy and without other medical co-morbidities. In contrast, the patient in the current survey requires more time for pre-anesthesia evaluation, as well as preparation of equipment and medications and the need for vasoactive infusions. In

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addition, the current patient often has cardiac and other co-morbidities. This change in patient population is well described in a 2014 article published in the *Journal of Cardiothoracic and Vascular Anesthesia* wherein the authors provide a clear picture of the complexity of the patients, challenges of the environment of care, the risk of significant complications, and the ongoing intensity of effort required to coordinate with the proceduralist throughout a lengthy intervention.¹

The RUC noted that it anticipates this patient population will become even more complex in the future.

Change in technique

The anesthetic care required is different for the current vignette patient than in previous vignette patients. For the young patient with WPW, moderate to deep sedation was the primary anesthetic plan and no invasive monitoring was required. For the PVI technique, the typical anesthesia approach requires general anesthesia with endotracheal intubation. General anesthesia is chosen to provide better patient comfort, immobility throughout the catheterization of the pulmonary vein and during the ablation, control and modification of ventilation patterns (which can affect the ablation), and better outcomes for the ablation. Ongoing communication and close coordination between the anesthesiologist and cardiologist are required throughout the duration of the procedure in order to provide optimal conditions for the ablation technique and to avoid or permit the early detection of major complications.

A 2018 article in the *Journal of Cardiothoracic and Vascular Anesthesia* describes the increasing demands on anesthesiologists performing this procedure and that anesthesiologists are becoming integral members of the electrophysiologic teams. The authors find that as the complexity and duration of cardiac ablation procedures increase, there is a growing demand for anesthesiologist involvement in the electrophysiology suites for sedation and anesthesia provision, hemodynamic and neuromonitoring, and procedural guidance through transesophageal echocardiography. The authors conclude that, “As the population ages and EP technologies improve, the scope of practice will grow to include more elderly, more moribund, and more complex patients, including those with CHD and VADs.”²

00537 Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation

The RUC reviewed the survey results from 100 anesthesiologists and recommends the median base unit of 12 for CPT code 00537. The RUC recommends 16 minutes pre-anesthesia patient evaluation time, 15 minutes pre-anesthesia equipment/drug/supply preparation time, 15 minutes intra-operative anesthesia induction time, 180 minutes intra-operative anesthesia post-induction time and 12 minutes post-anesthesia evaluation time. The majority of survey respondents indicated that the intensity and complexity measures for 00537 are identical to slightly more to somewhat more intense than top key reference service 00560 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator* (base unit = 15) and identical to slightly more intense than the second top key reference service 00350 *Anesthesia for procedures on major vessels of neck; not otherwise specified* (base unit = 10), which bracket the base unit recommendation. The RUC noted that the surveyed code requires 180 minutes post-induction intra-operative anesthesia time, where 00560 requires 152 minutes and 00350 requires 120 minutes.

For further support, the RUC also referenced other cardiac related anesthesia services such as CPT code 00534 *Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator* (base unit

¹ Nicoara, A., Holmquist, F. et al. (2014). Anesthesia for Catheter Ablation Procedures. *Journal of Cardiothoracic and Vascular Anesthesia*; 28(6), 1589-1603. <http://dx.doi.org/10.1053/j.jvca.2014.05.030>

= 7) and 00541 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation* (base unit = 15).

The RUC-approved anesthesia building block methodology and regression analysis are important tools to compare relativity among anesthesia services and are used to validate the recommendation. The regression line graph in the summary of recommendation form supports the recommended base unit of 12 as it is the closest base unit value to the regression line. The closer a point is to the regression line, the better the agreement between the proxy RVU value derived from the building block methodology and the actual base unit.

Post-Induction Period Procedure Anesthesia (PIPPA) is the relative intensity methodology used to validate base unit values. Survey respondents were asked to allocate the post induction period to five different intensity levels. PIPPA only looks at the post-induction period and it is conceptually equivalent to the time during which the surgeon performs the procedure. CPT code 00537 has a greater overall amount of time spent in the higher PIPPA levels in comparison to the top key references but falls in line with the overall weighted PIPPA intensity for 00537 (0.0503), compared to 00350 (0.0513) and 00560 (0.0583).

The RUC agreed that the survey median base unit of 12 appropriately places 00537 in the proper rank order with other anesthesia services when examining the anesthesiologists' time, PIPPA levels of intensity, the proxy anesthesia value and regression line. **The RUC recommends a base unit of 12 for CPT code 00537.**

Practice Expense

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

Treatment of Foot Infection – Tab 14

Brooke Bisbee, DPM (APMA); William Creevy, MD (AAOS); Hussein Elkousy, MD (AAOS) and Peter Mangone, MD (AOFAS)

Facilitation Committee #3

In October 2019, the RUC identified CPT code 28002 *Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space* via the 010-day global period service with more than one office visit and Medicare utilization greater than 1,000 screen. Codes 28001 and 28003 were added as family codes for review. When considering typical patient vignettes for a RUC survey, the stakeholder societies noted that these three major surgical procedures did not have a consistent global period; 28001 and 28002 have a 010-day global period and 28003 has a 90-day global period. The specialty societies and the RUC also noted that code 28002 had over 60% of claims in the inpatient setting, however, code 28002 only included 0.5 x 99238 which corresponds to same-day outpatient status. The specialty societies determined that there is a significant heterogeneity in the complexity of the patient population for this family of codes so as to make it problematic to identify the typical patient for the purpose of estimating typical hospital and office visits in a global period; the severity of underlying comorbidities will require differing number and level of follow-up care and patient presentation can change from year to year. Based on this information, the specialty societies sent a request to CMS through AMA staff to change the global period assignment for all three codes to 000-day. The societies indicated that a 000-day global assignment will provide more accurate reporting of post-operative work for this multi-modal family of codes. CMS did not respond to this request and a survey was conducted for all three codes as 000-day global. In January 2020, the RUC recommended this service be surveyed for April 2020; this issue was postponed until the October 2020 RUC meeting.

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28001 Incision and drainage, bursa, foot

The RUC reviewed the survey results from 164 podiatrists and orthopaedic surgeons for CPT code 28001 and determined that the survey median work RVU of 2.00 for podiatrists with 60 minutes total time appropriately accounts for the work required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 20 minutes intra-service time, and 15 minutes immediate post-service time. The RUC noted that this service is primarily performed by podiatrists (99%) in the non-facility setting (2019 Medicare data), supporting the use of the median response rate of podiatrists to assign a value. The RUC also noted and discussed the bimodal distribution of the survey data; the responses from the orthopaedic surgeons suggest a different patient population and possibly different physician work that the specialty societies could consider in future coding recommendations. The RUC noted supporting reference services that have the same intra-service time and similar total time: CPT code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU = 2.00, 20 minutes intra-service time and 57 minutes total time) and 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU = 2.00, 20 minutes of intra-service time and 58 minutes total time). **The RUC recommends a work RVU of 2.00 for CPT code 28001.**

28002 Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space

The RUC reviewed the survey results from 164 podiatrists and orthopaedic surgeons for CPT code 28002 and determined that the survey median of 3.73 work RVUs slightly overestimated the work required to perform this service. The RUC recommended a direct work RVU crosswalk to CPT code 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy*; (work RVU = 3.50, 15 minutes of pre-service evaluation time, 8 minutes of pre-service positioning time, 13 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 20 minutes of immediate post-service time) as it has the same intra-service time. The RUC noted that although 31287 had less total time than 28002, the intensity of 31287 was greater, lending support for crosswalking the work RVU of 31287 to 28002. The RUC recommends 30 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 20 minutes of immediate post-service time. The RUC noted that because CPT code 28002 is typically performed in the facility setting, there was not a bimodal patient distribution to consider. For additional support, the RUC referenced CPT code 41530 *Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session* (work RVU = 3.50, 20 minutes intra-service time and 95 minutes total time) and 52334 *Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde* (work RVU = 3.37, 30 minutes intra-service time and 75 min total time). **The RUC recommends a work RVU of 3.50 for CPT code 28002.**

28003 Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

The RUC reviewed the survey results from 164 podiatrists and orthopaedic surgeons for CPT code 28003 and determined that the survey median work RVU of 5.28 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 10 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, and 20 minutes of immediate post-service time.

The RUC noted that there was again a bimodal distribution in the survey responses comparing podiatrists to orthopaedic surgeons; while this might represent different patient populations and different physician work for the two specialties, the specialty societies' expert panel recommended the combined median work RVU recommendation. The specialty societies indicated, and the RUC agreed, that CPT code 28003 CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

is appropriately more work than 28001 and 28002 because it is a more complex procedure involving multiple and deeper tissue and sinus tract exploration. The RUC compared CPT code 28003 to the top two key reference services CPT code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU = 4.10, total time of 116 minutes, pre-service evaluation time of 33 minutes, pre-service positioning time of 3 minutes, pre-service scrub/dress/wait time of 15 minutes, intra-service time of 45 minutes, and immediate post-service time of 20 minutes) and CPT code 20245 *Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)* (work RVU = 6.00, total time of 160 minutes, pre-service evaluation time of 40 minutes, pre-service positioning time of 15 minutes, pre-service scrub/dress/wait time of 15 minutes, intra-service time of 60 minutes, and immediate post-service time of 30 minutes). Both of these codes bracket the recommended work RVU of 5.28 for code 28803. This work RVU recommendation is supported by 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), which has the same intra-service time of 45 minutes and 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.35), which has a slightly higher work RVU, the same intra-service time of 45 minutes and only 5 minutes more total time.

The RUC recommends a work RVU of 5.28 for CPT code 28003.

Practice Expense

The Practice Expense Subcommittee discussed the pre-service clinical staff time (CA001-CA005) related to changes in the global period for these three codes. The pre-service clinical staff times for CPT code 28003 were adjusted to the 000-day standard for Extensive Use of Clinical Staff in the facility setting to account for the global period change from 090-day to 000-day. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Needle Biopsy of Lymph Nodes – Tab 15

Curtis Anderson, MD, PhD (SIR); Lauren Golding, MD (ACR); Minhaj Khaja, MD (SIR); Andrew Moriarity, MD (ACR) and Kurt Schoppe, MD (ACR)

CPT code 38505 *Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)* was identified in October 2019 as Harvard Valued utilization over 30,000. In January 2020, the RUC recommended to survey for October 2020.

Compelling Evidence

The specialty societies provided compelling evidence and the RUC agreed that the work has changed for CPT code 38505 based on change in dominant specialty now reporting this service. Based on Medicare utilization data from 1993, the dominant specialty for 38505 was Otolaryngology, followed by General Surgery, and subsequently followed by Diagnostic Radiology. Most recent Medicare utilization data from 2019 indicates Diagnostic Radiology as the dominant specialty at 77% followed by Interventional Radiology at 13%. Additionally, the RUC proposed that there was compelling argument for a change in procedure as this service now involves larger tissue samples as well as a change in technology. Improved treatment options for oncology patients based on molecular markers and closer interval follow-up has increased the importance of tissue sampling. Improvements in technology allowing larger core biopsy sample sizes has increased the utility of needle core biopsy as an alternative to open surgical biopsy or excision. Needle biopsy of lymph nodes requires careful attention to adjacent vascular structures and other surrounding anatomy. In the typical case of jugular chain node biopsy, the physician must take care to avoid injuring the jugular vein and vagal nerve with needle placement.

38505 Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)

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Approved by the RUC January 14, 2021

The RUC reviewed the survey results of 62 radiologists and interventional radiologists and recommends the survey 25th percentile work RVU of 1.59 for CPT code 38505. The RUC recommends 13 minutes pre-service evaluation time, 1 minute positioning, 5 minutes scrub, dress and wait time, 20 minutes intra-service time and 10 minutes immediate post-service time. The survey total time differs by one minute compared to the total Harvard time. The Harvard time was established prior to the development of pre and post-service time packages. However, the Harvard times should not be compared to the new survey time because that time does not represent how this service is now performed and the type of physician performing it. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IPUT for the current times and valuation are inappropriately low for a surgical procedure (0.0231), which strongly implies the current times are inflated relative to the current work RVU and not valid for comparison to the new times. Additionally, the pre- and post-operative work were computed by algorithm.

The RUC compared CPT code 38505 to the top key reference service, CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 25 minutes intra-service time and 50 minutes total time), which have nearly identical total times. These procedures are very similar in that they both typically involve needle biopsy of small structures in the neck, requiring attention to vascular structures and the lung apices. Most of the survey respondents that selected this reference code characterized CPT code 38505 as requiring more mental effort and judgement than CPT code 60100 and reported CPT code 38505 as somewhat more intense/complex overall than CPT code 60100. Thyroid biopsies are typically performed on relatively healthy patients while lymph node biopsies are frequently performed in patients with malignancy or infection. The similarity of these procedures with nearly identical total times supports nearly identical work values. The second top key reference service code, CPT code 20225 *Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)* (work RVU = 2.45 and 30 minutes intra-service time) has a higher work RVU, but also more total time. CPT code 20225 describes a deep biopsy which requires both more time and is more intense than a lymph node biopsy and is appropriately valued higher than 38505.

For additional support, the RUC compared CPT code 38505 to MPC codes 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 1.75, 15 minutes intra-service time and 40 minutes total time) and 90945 *Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional* (work RVU = 1.56, 27 minutes intra-service time and 47 minutes total time). CPT code 38505 requires more intra-service and total time to perform than MPC code 36556. However, because CPT code 36556 is typically performed in the inpatient setting for acute indications such as sepsis, the intensity of the service is greater and accounts for the higher work value of 1.75. MPC code 90945 has 7 more intra-service minutes, but nearly identical total time compared to 38505. A portion of the intra-service time for 90945 is spent supervising dialysis, which is less intense than the intra-service work of 38505. The higher intensity of 38505 accounts for the differences in intra-service time but similar values. **The RUC recommends a work RVU of 1.59 for CPT code 38505.**

Practice Expense

The RUC recommends the direct practice expense inputs as submitted by the specialty societies.

Placement/ Removal of Seton – Tab 16

Charles Mabry, MD, FACS (ACS); Guy Orangio, MD, FACS (ASCRS) and Stephen Sentovich, MD, FACS (ASCRS)

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Approved by the RUC January 14, 2021

In October 2019, the RUC identified CPT code 46020 via the 010-day global period service with more than one office visit. In January 2020, the RUC recommended for this service to be surveyed for April 2020 and CPT code 46030 was added for review since it is part of the same code family. This issue was postponed until October 2020 RUC meeting.

Compelling Evidence

The RUC reviewed and agreed that there is compelling evidence that codes 46020 and 46030 are potentially misvalued based on flawed assumptions and a flawed valuation methodology when 46020 was last reviewed 20 years ago and a change in the specialty performing 46030 from when it was last reviewed during the Harvard study. For CPT code 46020, the specialties provided historical documents that showed how the RUC survey at that time requested physician time and visit information for *both* the survey code and the key reference code that was chosen. The data from that the survey time for the key reference code 46230 is almost identical to the survey time for code 46020. The RUC concurred with the specialties that the original valuation for new code 46020 used a flawed methodology that resulted in undervaluation because the recommendation was based on comparison of time data for 46230 collected via survey as a reference code that was significantly greater than the actual Harvard time. The time and visit data differences were not appropriately compared nor was the resulting IWP. Even though the pre-, intra-, and post-work were clearly significantly greater (an approximate 70% differential), a value was assigned that was minimally greater (14%). In 2001, the RUC modified the standard survey templates to remove the question asking for reference code times due to the question's lack of utility. Separately, the standard reference service list (RSL) for all colorectal surveys in 2000 included codes spanning all global periods. At that time, only three codes were included on the RSL had a 10-day global period—all of these were Harvard codes—and the survey instructions were clear that the survey respondent should pay attention to the global period when selecting a reference code.

For 46030, the Harvard physician work survey only captured data from 17 responses which were all general surgeons and only for intraoperative work. The pre- and post-operative work were computed by algorithm. Now, colorectal surgery is the dominant provider. The RUC accepted compelling evidence for code 46030 based on a change in the specialty performing the procedure and the current dominant specialty not having been involved in the prior review process.

46020 Placement of seton

The RUC reviewed the survey results from 110 colorectal and general surgeons and recommends the survey median work RVU of 3.50 for CPT code 46020. The RUC recommends 30 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 30 minutes of intra-service time and 20 minutes of immediate post-service time. The additional positioning time relative to the standard package is due to the additional time needed to place the patient prone jackknife with the appropriate padding and restraints, effacing the buttocks with tape stretched to table, prep and drape. The RUC noted that the current times for this service are 20 years old and not valid for comparison due to the flawed assumptions detailed above. The IWP for the current times are not much higher than that of scrub/dress/wait IWP, which strongly implies the current times are highly inflated relative to the current work RVU and not valid for comparison to the new times.

The specialty noted and the RUC agreed that the global period change from 010-day global to 000-day global was warranted as followup care of the patient will be highly variable, based on the complexity of the fistula and comorbid conditions (eg, Crohn's). A seton is typically placed under anesthesia in an OR and is typically left in place for 8-12 weeks (or indefinitely in some cases), with the purpose of providing controlled abscess drainage, thereby allowing all the inflammation to subside and form a solid tract of scar along a fistula tract.

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Approved by the RUC January 14, 2021

To justify a work value of 3.50, the RUC compared the survey code to 2nd key reference code 45380 *Colonoscopy, flexible; with biopsy, single or multiple* (work RVU= 3.56, intra-service time of 28 minutes, total time of 65 minutes) and noted that both services have similar intra-service times and should be valued similarly. Code 45380 is typically performed under moderate sedation with the patient self-positioning on their left side. The greater preoperative time for 46020 is related to anesthesia, positioning, and evaluation of a patient with an active disease (Crohn's) prior to surgery. Like CPT code 46020, time is needed to traverse a "tract" (fistula versus colon). Postoperative time for CPT code 45380 may be less than CPT code 46020 due to the differences in anesthesia recovery. The RUC also compared the survey code to CPT code 43194 *Esophagoscopy, rigid, transoral; with removal of foreign body(s)* (work RVU= 3.51, intra-service time of 30 minutes, total time of 107 minutes) and noted that both services have identical intra-service times and similar total times. **The RUC recommends a work RVU of 3.50 for CPT code 46020.**

46030 Removal of anal seton, other marker

The RUC reviewed the survey results from 110 colorectal and general surgeons and recommends the survey median work RVU of 2.00 for CPT code 46030. The RUC recommends 17 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 15 minutes of intra-service time and 15 minutes of immediate post-service time. The additional positioning time relative to the standard package is due to the additional time needed to place the patient prone jackknife with the appropriate padding and restraints, effacing the buttocks with tape stretched to table, prep and drape.

The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWP/PUT for the current times and valuation are inappropriately low for a major surgical procedure, which strongly implies the current times are inflated relative to the current work RVU and not valid for comparison to the new times. The Harvard study physician work survey for this code only captured data from 17 responses which were all general surgeons and only for intraoperative work. The pre- and post-operative work were computed by algorithm.

The specialty noted and the RUC agreed that the global period change from 010-day global to 000-day global was warranted as follow-up care of the patient will be highly variable. Sometimes removal of a seton may not require an E/M post-op visit related to the removal of the seton or that visit may occur more than 10 days after the procedure.

To justify a work value of 2.00, the RUC compared the survey code to MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU= 1.90, intra-service time of 15 minutes, total time of 45 minutes) and note that although both services have identical intra-service times, the survey code involves much more total time. The RUC also compared the survey code to CPT code 15040 *Harvest of skin for tissue cultured skin autograft, 100 sq cm or less* (work RVU= 2.00, intra-service time of 15 minutes, total time of 60 minutes) and noted that both services involve identical intra-service times and similar total times. **The RUC recommends a work RVU of 2.00 for CPT code 46030.**

Practice Expense

The Practice Expense Subcommittee discussed the pre-service clinical staff time (CA001-CA005) related to changes in global periods. The pre-service clinical staff times for CPT code 46030 were adjusted to the standard for Extensive Use of Clinical Staff in the facility setting to more appropriately account for the global period change from 010-day to 000-day. Also, the supply inputs were modified to remove SB018 *drape-sleeve, sterile, for handpiece*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Destruction by Neurolytic Agent – Tab 17

Neal Cohen, MD (ASA); Damean Freas, MD (NANS); Wesley Ibazebo, MD (SIS); Kano Mayer, MD (NASS); Carlo Milani, MD (AAPM&R); Gordon Morewood, MD, MBA (ASA); Gregory Polston, MD (AAPM); David Reece, DO (AAPM&R); Richard Rosenquist, MD (ASA) and Karin Swartz, MS (NASS)

In September 2014, the Relativity Assessment Workgroup identified a work neutrality issue for CPT codes 64633-64636 related to incorrect coding relative to how the services were originally valued. Due to the nature of the possible incorrect coding of per nerve instead of per joint, the specialties were encouraged to immediately begin addressing this coding education and clarification. The RUC recommended that the specialty societies develop a CPT Assistant article to address this issue. The specialty societies submitted a CPT Assistant article stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as it did previously (publication date: February 2015). In January 2015, the Relativity Assessment Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. The RUC recommended that the specialty societies immediately submit revised introductory language to the CPT Editorial Panel to address any inappropriate coding regarding reporting per nerve instead of per joint issue (for CPT 2016). The RUC requested that AMA staff compile data on how many times a service is reported for the same patient on the same day and 2014 preliminary Medicare utilization. The Workgroup reviewed the additional data in April 2015. The Workgroup agreed that the specialty societies took aggressive action to ensure correct reporting of these services. The Workgroup recommended to allow the multiple efforts to take effect and re-review the utilization data for these services in April 2017. In May 2015, the CPT Editorial Panel revised the parenthetical instructions for the five codes describing paravertebral facet joint nerve destruction to clarify that these codes are reported per joint, not nerve. In April 2017, the specialty society indicated, and the Workgroup agreed that recent CPT changes did not take effect until 2016 and the Medicare utilization was not available when preparing for this meeting. The Workgroup recommended that more time was necessary to determine CPT changes were effective and that the Workgroup review these services in October 2019 when two years of Medicare utilization data are available. In October 2019, the Workgroup thoroughly discussed the history of this family, noting that although the specialty used best efforts to estimate utilization and distribution of reporting these services, the original recommendations were not work neutral and compelling evidence had not been approved. The Relativity Assessment Workgroup noted that the growth in these services is appropriate as the patient population requiring these services has grown. However, due to the extensive growth and original incorrect assumptions about distribution of reporting, the Workgroup determined that a new survey is required. A member questioned if the codes should be surveyed using a 000 global period, rather than the current 010-day global period. The specialty societies confirmed that 64633 and 64635 should be maintained as 010-day global periods. The RUC recommended that CPT codes 64633-64636 be surveyed.

64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

The RUC reviewed the survey responses from 166 physicians and determined that a work RVU of 3.42 appropriately accounts for the physician work necessary to perform this service and matches the survey median of family code 64635. The RUC recommends the same survey median work RVU as 64635 for CPT code 64633 because the surveys indicate that these two services require the exact same physician time to perform and are performed on anatomically similar structures in the lumbar and cervical spine respectively. The RUC was concerned that the survey 25th percentile work RVU of 3.36 for CPT code 64633 is too low and would create a rank order anomaly with 64635. To prevent such an anomaly, the RUC recommends the same median value as 64635 as supported by the survey.

The RUC recommends 18 minutes pre-evaluation time, 5 minutes positioning time, 5 minutes scrub, dress and wait time, 20 minutes intra-service time, 10 minutes immediate post time, a half discharge day management and one 99213 office visit. The RUC confirmed that the half discharge day management is appropriate as this service is typically performed in the hospital or ambulatory surgery center setting.

The RUC compared CPT code 64633 with the top key reference service 64625 *Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)* (work RVU = 3.39, 30 minutes intra-service time and 98 minutes total time).

CPT code 64633 is slightly more intense and complex than the reference code due to the anatomical differences in locations. While CPT code 64625 requires more injections, CPT code 64633 is in a much more clinically complex location, cervical or thoracic, requiring greater clinical expertise. CPT code 64633 also requires more total time than 64625 and the recommended higher work RVU maintains the proper rank order between these two services. For further support the RUC compared CPT code 64633 to MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU = 3.42 and 93 minutes total time), which requires the same physician work but slightly less total time. **The RUC recommends a work RVU of 3.42 for CPT code 64633.**

64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)

The RUC reviewed the survey responses from 164 physicians and recommends maintaining the current work RVU of 1.32 for CPT code 64634, which is lower than the survey 25th percentile of 1.50. The RUC recommends 20 minutes intra-service time for this add-on service. The RUC noted that 64634 requires more physician time and work than 64636 to account for the neurovascular structures in the cervical spine, making sure that the positioning is appropriate and safe. It requires more time to focus the correct targets on the cervical spine and the physician must correctly position the shoulder and visualize the correct anatomy.

The RUC compared CPT code 64634 to the top key reference service 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)* (work RVU = 1.39 and 25 minutes intra-service time). The RUC determined that 64634 requires less physician time to perform. Thus, is valued appropriately slightly less than key reference service 64645. The RUC also compared 64634 to the second key reference service 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16 and 15 minutes intra-service time). The RUC concurred that the physician time, technical skill, stress, and intensity of add-on code 64634 is greater than that of 64491.

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For further support the RUC notes that CPT code 64634 is appropriately bracketed by MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 20 minutes intra-service time) and 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.32 for CPT code 64634.**

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

The RUC reviewed the survey responses from 167 physicians and recommends the survey median work RVU of 3.42 for CPT code 64635. Due to the decrease in physician time the RUC determined that the decrease in work RVU was warranted. The RUC recommends 18 minutes pre-evaluation time, 5 minutes positioning time, 5 minutes scrub, dress and wait time, 20 minutes intra-service time, 10 minutes immediate post time, a half discharge day management and one 99213 office visit. The RUC confirmed that the half discharge day management is appropriate as this service is typically performed in the hospital or ambulatory surgery center setting. The RUC noted that CPT codes 64633 and 64635 require the exact same physician time and work to perform and therefore should be valued the same.

The RUC compared CPT code 64635 with the top key reference service 64625 *Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)* (work RVU = 3.39, 30 minutes intra-service time and 98 minutes total time).

CPT code 64635 is slightly more intense and complex than the reference code due to the anatomical differences in locations. While CPT code 64625 requires more injections, CPT code 64635 is in a much more clinically complex location, lumbar or sacral, requiring greater clinical expertise. CPT code 64635 also requires more total time than 64625 and the recommended higher work RVU maintains the proper rank order between these two services. For further support the RUC compared CPT code 64635 to MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU = 3.42 and 93 minutes total time), which requires the same physician work but slightly less total time. **The RUC recommends a work RVU of 3.42 for CPT code 64635.**

64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)

The RUC reviewed the survey responses from 166 physicians and recommends maintaining the current work RVU of 1.16 for CPT code 64636. The RUC recommends 15 minutes intra-service time for this add-on service.

The RUC compared CPT code 64636 to the top key reference service CPT code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16 and 15 minutes intra-service time) noting that these services require the exact same physician work and intra-service time. The RUC also compared 64636 to the second top key reference service 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)* (work RVU = 1.39 and 25 minutes intra-service). The RUC determined that 63635 requires less physician time and work to perform. Thus, is valued appropriately less than key reference service 64645.

For further support the RUC references MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minute intra-service time) which requires the same physician time and similar physician work. **The RUC recommends a work RVU of 1.16 for CPT code 64636.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made minor modifications to the clinical staff time and to the supply items, noting that the SA041 *pack, basic injection* includes 10 ml povidone solution (Betadine) which may no longer be typical and could possibly be replaced by chlorhexidine in the future. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Work Neutrality

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

RUC Database Flag

The RUC will flag CPT code 64633 as "do not use for comparison" in the RUC database since the work RVU recommendation was the survey median for CPT code 64635, which is currently under review with this service.

Strabismus Surgery – Tab 18

John Bishop, MD (AAP); David B. Glasser, MD (AAO); Steven E. Krug, MD (AAP); Michael X. Repka, MD, MBA (AAO) and Ankoor Shah, MD (AAO)

After the RUC reviewed the Evaluation and Management (E/M) office visits in April 2019, it also recommended that the increases for physician work and time, if accepted, should be incorporated into the surgical global periods for each CPT code with a global of 010-day, 090-day and MMM (maternity) codes. When AMA staff compiled the list of 010-day, 090-day and MMM services in which these changes should be applied, they noticed that several low volume codes that were converted to ZZZ global periods in 1999 still included office visits (CPT codes 67320, 67331, 67332, 67334, 67340). It appeared that these office visits may not be appropriate for these services. Additionally, these services received the increase in 2007, when the E/M increases were applied to the surgical global periods. The RUC noted that these services 1999 work RVUs were calculated and the methodology used would not be a valid methodology today and the physician times are based on Harvard data. The RUC recommended that add-on codes 67320, 67331, 67332, 67334, 67335, and 67340 be surveyed for April 2020 along with the base codes in which these services are typically reported (CPT codes 67311, 67312, 67314, 67316 and 67318). This issue was deferred until October 2020.

In May 2020, the specialties reported an incident with a communication during the survey period containing the current publicly available work RVUs for the 11 codes. The RUC discussed extensively and determined that only the pre-disclosure data obtained from the period prior to the communication would be used for valuation, thus maintaining the integrity of the survey data.

Compelling Evidence

The family of five 090-day global base codes and six ZZZ add-on codes comprises the entirety of strabismus eye muscle surgery procedures in the CPT code set. All five base codes are Harvard-valued, and all eleven codes retain Harvard times. The family was identified because five of the add-on codes carried postoperative visits in the database. While this was a clerical error as the work value associated CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

with the visits had been removed in 1999, all eleven codes were presented to the RUC for valuation. Although it was not needed overall for the family, the specialty societies presented compelling evidence as there are two codes proposed to increase in value, CPT codes 67318 and 67335. The RUC noted that the recommendations for the family of strabismus codes will result in an overall work savings to be redistributed back to the Medicare conversion factor. The RUC reviewed and accepted compelling evidence based on flawed methodology as outlined below.

The current times for these services are over 25 years old from the Harvard study and not valid for comparison. During the initial Harvard study, only overall post-operative time was surveyed; data on the number and level of hospital and office post-operative visits were not collected. These times were "converted" to E/M visit codes by a CMS contractor for practice expense RVU review using an algorithm some years after the original Harvard study. Thus, this is the first time the RUC reviewed the hospital and office visits for these services and the first time survey data was collected on the number and level of post-operative visits, making comparison between historic Harvard times and modern RUC times highly inappropriate for major surgical procedures.

There is compelling evidence that the add-on codes in this family were valued using improper methodology during a value correction in 1998, resulting in anomalous value relationships among all the codes under review. CPT add-on codes 67320, 67331, 67332, 67334 and 67340 each have 4 postoperative visits listed in the database as well as pre- and post-time. They were last evaluated by the RUC in May 1998. These codes were changed from stand-alone codes with a global period of 090 days to add-on ZZZ codes. The rationale to adjust their value at the May 1998 RUC meeting reads:

The family of add-on codes in the Strabismus Surgery section of CPT were reevaluated as they are currently identified as stand-alone codes with a global period of 90 days. Previously, the descriptors for CPT codes 67320, 67331, 67332, 67334 and 67340 included not only the intra-service work described by the code, but also a number of unstated, but implied, services that are associated with pre-service and post service work. These codes will now be identified as add-on codes with a global period of ZZZ and the work rvus should be reduced accordingly.

The RUC recommends the following work values: 4.33 (67320); 4.06(67331); 4.49 (67332); 3.98 (66334); 4.93 (67340). The specialty society used an arithmetic adjustment to the work values of these procedural codes. These proposed values were established by reducing the current work values by 50% using rules for multiple surgical procedures performed on the same day. Also, the Harvard data indicates that 59% of the codes were for intra-work, further justifying these proposed work values.

The RUC database confirms those reductions were implemented in the RUC recommendations and accepted by CMS for 1999:

1998	1999	2018	Claims
CPT	RVU	RVU	
+67320	8.26	4.33	369
+67331	8.12	4.06	866
+67332	8.99	4.49	1,682
+67334	7.96	3.98	128
+67335	2.49	2.49	1,756
+67340	9.85	4.93	68

When the ZZZ-global codes were revalued in 1998 to address the inaccurate inclusion of postoperative visits by the Harvard surveyors, they were valued by applying 50% multiple procedure payment reductions (MPPR) to the initial Harvard valuations. This is no longer an accepted methodology. The use of this methodology created anomalous relationships within the family and distorted relativity with the remainder of the RUC database.

All the base codes in the family and add-on code 67335 were excluded in the group of codes revalued in 1998. CPT code 67335 was initially Harvard valued as a ZZZ code with no pre- or post-time or postoperative visits. Excluding this code and all the 090-day global base codes within the family from the 1998 revaluation process was also flawed methodology which allowed the rank order anomalies to continue.

There is also the argument that Harvard-based times and work values are no longer consistent with RUC methodology that has been in place for the last two decades and which has generated the values for those frequently performed procedures in the database that make up the bulk of Medicare claims volume. Whether outdated Harvard methodology is sufficient compelling evidence in and of itself, the use of an MPPR calculation to value only some of the add-on procedures in the family and the exclusion of the base codes from the valuation process in 1998 is certainly inconsistent with today's accepted RUC methodology. The RUC accepted compelling evidence based on flawed methodology and believes that the arguments presented help to build the case for the proposed RVU recommendations given the decreases in time reflected in the survey.

Intensity

The strabismus procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and suturing them to the sclera. Shortening muscle procedures (resections) are significantly more difficult and complex than repositioning muscle procedures (recessions). They may be performed in all age groups. The base codes are typically performed in children at risk of amblyopia and loss of binocular vision from suppression of the image from one eye, and involve deep scleral placement of sutures, within 0.5 mm of the retina. These factors contribute to the intensity and complexity of these procedures being relatively high compared to most other ophthalmic procedures.

While it may seem that the intensity of work for each of the base codes might be similar, there are marked differences between single-muscle and two-muscle procedures and surgery on the superior oblique muscle. Single-muscle procedures are typically recessions, where the muscle insertion is detached and reattached further posteriorly on the globe, in effect "lengthening" the muscle. Two-muscle procedures typically involve a recession of one muscle and a resection of the second muscle; thus, it is not simply performing the same procedure twice. The resection component of the procedure requires detachment of CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

the muscle from its insertion, resection of a specific length of the muscle, and reattaching it, in effect “shortening” the muscle. Muscle resections are markedly more intense and complex than recessions. This makes 2-muscle procedures significantly more intense and complex than 1-muscle procedures, independent of the increased time required to operate on 2 muscles. Surgery on the superior oblique muscle, because of its insertion location, reflected tendon, posterior location, small size and difficulty in isolating the muscle, is more difficult than surgery on horizontal or vertical rectus muscles. It is similar in intensity and complexity to that of the 2-muscle procedures.

Based on the relative intensity and complexity of the base codes and to avoid rank-order anomalies, the RUC noted that the single-muscle procedures (CPT codes 67311 and 67314) should have lower intensity than the two-muscle procedures (CPT codes 67312 and 67316) or the superior oblique procedure (CPT code 67318). The two-muscle procedures and the superior oblique procedure should have similar intensity.

Base Codes

67311 Strabismus surgery, recession or resection procedure; 1 horizontal muscle

CPT code 67311 is a procedure on a single horizontal muscle, typically a medial rectus recession to correct esotropia in a child. The RUC reviewed the survey results from 62 ophthalmologists and pediatric ophthalmologists and determined that a direct work RVU crosswalk to CPT code 53854 *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (work RVU = 5.93, 25 minutes intra-service time and 137 minutes total time) accurately reflects the physician work necessary for this service and falls below both the survey 25th percentile and the survey low response.

The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 25 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The 2-99212 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The RUC compared CPT code 67311 to the top key reference service and MPC code 67904, *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, 45 minutes intra-service time and 185 minutes total time) and noted that the intra-service time is almost double that of the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67311 is considered more intense, with over 70% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

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For additional support, the RUC referenced key MPC codes 26765 *Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each* (work RVU = 5.86, 45 minutes intra-service time and 217 minutes total time) and 25071 *Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater* (work RVU = 5.91, 45 minutes intra-service time and 178 minutes total time) and noted the similar amount of physician work but longer times for the comparison codes. The RUC reiterated that the survey code current times are Harvard-source and not valid for comparison.

The RUC concluded that CPT code 67311 should be valued based on a direct work RVU crosswalk to CPT code 53854 with times as supported by the survey. **The RUC recommends a work RVU of 5.93 for CPT code 67311.**

67312 Strabismus surgery, recession or resection procedure; 2 horizontal muscles

CPT code 67312 is a procedure on 2 horizontal muscles of the same eye, typically a recession of the medial rectus and a resection of the lateral rectus to correct esotropia in a child with a larger deviation than can be corrected with single-muscle surgery (CPT code 67311). The muscle resection makes it significantly more intense and complex than that of a recession alone, so a recess-resect combination on two muscles is more than twice the intra-service physician work than a single muscle recession.

The RUC reviewed the survey results from 57 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 9.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 40 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The intensity associated with this value (0.153) is higher than that of the single-muscle codes, CPT codes 67311 and 67314. This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical component of this two-muscle procedure. It is, appropriately, almost identical to the intensity for CPT code 67316, two vertical muscles, which is 0.154 at the recommended value.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two 99212 visits are necessary to confirm healing of the conjunctiva, coverage of the operative site, and assess ocular alignment.

The RUC compared CPT code 67312 to the top key reference service and MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, 45 minutes intra-service time and 185 minutes total time) and noted that the intra-service time is 5 minutes less for the survey code and intensity is more justifying the higher value. CPT code 67312 is considered

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more intense, with nearly 2/3 of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared CPT code 67312 with the second key reference code 67966 *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (work RVU = 8.97, 60 minutes intra-service time and 200 minutes total time) and noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67312 is clearly considered more intense, with 80% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, 60 minutes intra-service time and 183 minutes total time) and 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, 60 minutes intra-service time and 207 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67312 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 9.50 for CPT code 67312.**

67314 Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)

CPT code 67314 is a procedure on a single vertical muscle other than the superior oblique, which is a lengthier procedure. It is typically a superior rectus recession performed to correct hypertropia in a child. The RUC reviewed the survey results from 54 ophthalmologists and pediatric ophthalmologists and determined that a direct work RVU crosswalk to CPT code 53854 *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (work RVU = 5.93, 25 minutes intra-service time and 137 minutes total time) would accurately reflect the physician work necessary for this service and falls well below the survey 25th percentile.

The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 26 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The intra-service time is within 1 minute of that of CPT code 67311, the single horizontal muscle procedure.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site

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was intact. The two 99212 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

The RUC compared CPT code 67314 to the top key reference service and MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, 45 minutes intra-service time and 185 minutes total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67314 is considered more intense, with over 70% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 26765 *Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each* (work RVU = 5.86, 45 minutes intra-service time and 217 minutes total time) and 25071 *Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater* (work RVU = 5.91, 45 minutes intra-service time and 178 minutes total time) and noted the similar amount of physician work but longer times for the comparison codes. The RUC reiterated that the survey code current times are Harvard-source and not valid for comparison.

The RUC concluded that CPT code 67314 should be valued based on a direct work RVU crosswalk to CPT code 53854 with times as supported by the survey. **The RUC recommends a work RVU of 5.93 for CPT code 67314.**

67316 Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)

CPT code 67316 is a procedure performed on two vertical muscles, typically a recession of the superior rectus and a resection of the inferior rectus to correct hypertropia in a child with a vertical deviation that is too large to be corrected with single-muscle surgery (CPT code 67314). The resection portion of the procedure makes it significantly more intense and complex than that of a recession alone, so a recess-resect combination on two muscles is more than twice the intra-service physician work than a single muscle recession.

The RUC reviewed the survey results from 50 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 10.31 accurately reflects the physician work necessary to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 1-99213 office visit and 2-99212 office visits. The intensity associated with the recommended value (0.154) is significantly higher than that of the single-muscle codes, CPT codes 67311 and 67314. This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical component of this service. It is, appropriately, almost identical to the intensity for CPT code 67312, two horizontal muscles, which is 0.153 at the recommended value.

For pre-service time, pre-service time package 3 was selected (straightforward patient, difficult procedure) as these are typically children with variable and difficult-to-measure ocular alignment requiring careful positioning under general anesthesia. Immediate pre-operative measurements must be compared to those performed in the office and the surgical plan reviewed. The package pre-service evaluation time was reduced from 33 minutes to match the survey time of 10 minutes. The survey positioning time of 5 minutes was maintained, longer than the package time of 3 minutes. Five minutes is

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necessary because the nature of the procedure requires precise positioning of the typical child under general anesthesia. The scrub/dress/wait survey time of 15 minutes matches that of the package and is necessary due to use of general anesthesia in the typical child.

The 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The two 99212 visits are necessary to confirm healing of the conjunctiva and assess ocular alignment.

The RUC compared CPT code 67316 to the top key reference service and MPC code 67036 *Vitrectomy, mechanical, pars plana approach*; (work RVU = 12.13, 50 minutes intra-service time and 250 minutes total time) and noted that the intra-service time is 5 minutes less for the survey code and intensity is more but the reference code has five 99213 postoperative visits resulting in much higher total time. CPT code 67316 is considered more intense, with nearly 2/3 of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared CPT code 67316 with the second key reference code 67966 *Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin* (work RVU = 8.97, 60 minutes intra-service time and 200 minutes total time) and noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67316 is clearly considered more intense, with nearly 90% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible* (work RVU= 10.03, 90 minutes intra-service time and 283 minutes total time) and 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes intra-service time and 141 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67316 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 10.31 for CPT code 67316.**

67318 Strabismus surgery, any procedure, superior oblique muscle

CPT code 67318 is a procedure on the superior oblique muscle, typically a resection or plication of the muscle, in effect shortening it to correct a superior oblique palsy and resulting hypertropia in a child. Some or all of the tendon is included. Superior oblique muscle surgery has its own code to distinguish it from surgery on a single vertical muscle because operating on the superior oblique typically takes longer and is more intense and complex than surgery on a single vertical muscle. The greater intensity is due to the smaller size, the posterior location of the tendon, more difficult to identify insertion of the superior oblique muscle, and the greater difficulty of a resection or plication in comparison with the recession typically performed on a single vertical or horizontal muscle.

The RUC reviewed the survey results from 50 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 9.80 accurately reflects the physician work necessary to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 40 minutes intra-service time and 15 minutes immediate post-service time, 0.5 99238 discharge visit, 2-99213 office visits and 1-99212 office visit. The proposed value is slightly higher than the code's current value of 9.12, as supported by compelling evidence and the robust survey data. The intensity associated with this value (0.149) is significantly higher than that of the other single-muscle codes, CPT codes 67311 and 67314. This is consistent with the increased intensity and complexity of performing a muscle resection which is a typical for this service. The intensity is, appropriately, very close to the intensity for the two-muscle procedures, CPT codes 67312 and 67316, which also include a muscle resection. The recommended work value is slightly higher than that of CPT code 67312 despite identical intra-service times of 40 minutes. This is partially attributable to the additional 99213 postoperative visit and partially attributable to the slightly greater intensity of operating on a superior oblique muscle compared to horizontal muscles. The recommended value therefore maintains an appropriate rank order within the family.

The first 99213 visit is required to perform a dilated examination of the peripheral retina to confirm that the scleral sutures used to reattach the muscle were not full-thickness and that the retina under the suture site was intact. The second visit, a 99212, is necessary to confirm healing of the conjunctiva and assess ocular alignment (horizontal, vertical, and torsional). The third visit, another 99213, confirms that vertical alignment is maintained after further healing and requires a dilated fundus exam to assess the fundus for degree of correction of ocular torsion. Because the superior oblique muscle intorts the eye in addition to depressing it, and symptoms or torsional misalignment are not typically expressed accurately by patients, the dilated fundus check for rotational alignment is necessary for current and future treatment. The requirement for two 99213 postoperative visits distinguishes this code from the other 090-day global codes in the family, which need only one 99213 postoperative visit.

The RUC compared CPT code 67318 to the top key reference service and MPC code 66170 *Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery* (work RVU = 13.94, 45 minutes intra-service time and 278 minutes total time) and noted that the intra-service time is 5 minutes less for the survey code and intensity is more but the reference code has nine postoperative visits resulting in much higher total time. CPT code 67318 is considered more intense, with most survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, 60 minutes intra-service time and 207 minutes total time) and 21015 *Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm* (work RVU = 9.89, 75 minutes intra-service time and 277 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67318 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 9.80 for CPT code 67318.**

Add-On Codes

The six add-on codes (CPT codes 67320, 67331, 67332, 67334, 67335 and 67340) are all performed with one or more of the base codes (CPT codes 67311, 67312, 67314, 67316 and 67318). Each add-on code represents a distinct procedure beyond the base code. The add-on describes physician work that is clearly separate and beyond the scope of work of the base code with which it is reported. Work descriptors were carefully developed over several iterations with input from CPT to arrive at descriptions which clearly CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

distinguish the add-ons from any base procedure they are reported with. There are no combinations of add-on and base codes that are performed together more than 75% of the time. Therefore, there was no need to create new combined codes. The add-on services are not adequately described with the -22 modifier (increased procedural services) because they each comprise separate and distinct additional services with varying times and intensities.

CPT codes 67320 (transposition), 67331 (prior eye surgery) and 67334 (posterior fixation) are similar in intensity to each other and intermediate in intensity between the one- and two-muscle 090-day global base procedures. CPT code 67332, a re-operation with scarring of the extraocular muscles, is the most intense and complex of the add-on procedures, with an intensity approaching that of the two muscle base codes. CPT codes 67335 (adjustable suture) and 67340 (detached muscle) are the least intense and complex of the add-on procedures and are slightly more difficult than the one muscle base codes. These variations in intensity and complexity relate to a variety of differences in the procedures that will be highlighted for each code.

Note: This family of codes was recommended for survey because five of the add-on codes (67320, 67331, 67332, 67334 and 67340) carried postoperative visits in the RUC database. These procedures were changed from 090-day global to ZZZ codes and work values were correspondingly reduced in 1999. However, the pre- and post-service times and the 4 postoperative visits were not removed from the RUC database. Therefore, the pre- and post-service times and postoperative visits and the intensity based on those times must be disregarded when comparing current values with the recommended times and work RVUs. On the Summary Spreadsheet, the erroneous times and postoperative visits have been removed from the "Current" row to provide a correct relativity comparison and a row has been added showing the pre-reduction data from 1998.

***67320 Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify)
(List separately in addition to code for primary procedure)***

CPT code 67320 is an add-on procedure typically performed for patients with a paretic lateral rectus muscle. It entails detaching the inferior and superior rectus muscles, repositioning them on the globe in an unusual location, and reattaching them in addition to the base procedure on the horizontal muscle(s). The need to relocate both muscles in an unusual location makes this procedure more intense than the single-muscle base procedures. It is not as intense as the two-muscle base procedures because it does not require a muscle resection.

The RUC reviewed the survey results from 51 ophthalmologists and pediatric ophthalmologists and determined that a direct work RVU crosswalk to CPT code 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 and total time) accurately reflects the physician work necessary for this service and falls below the survey 25th percentile. The RUC recommends 23 minutes intra-service time for this add-on code.

The RUC discussed that there are only two 23-minute ZZZ codes in the database: CPT codes 33517 *Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)* (work RVU = 3.61, 23 minutes intra-service time and 53.5 minutes total time) and 88350 *Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)* (work RVU = 0.59, 23 minutes intra-service and total time) and noted that neither are acceptable crosswalks. There are only two 24-minute ZZZ codes in the database, and both are Harvard valued. The RUC therefore chose CPT code 36907, a 25-minute ZZZ code, as an appropriate crosswalk. It yields an intensity of 0.130, which places CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

the survey code appropriately between the single- and two-muscle base codes and is almost identical to the intensity of similarly intense add-on codes 67331 and 67334.

To support the value, the RUC compared the survey code to 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)* and 32667 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* both of which have work RVUs = 3.00 and 25 minutes intra-service and total time.

The RUC also compared CPT code 67320 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67320 is considered more intense, with over 70% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced MPC codes 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65, 30 minutes intra-service and total time) and 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47, 45 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67320 should be valued based on a direct work RVU crosswalk to CPT code 36907 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 3.00 for CPT code 67320.**

67331 Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)

CPT code 67331 is an add-on procedure typically performed for patients with scarring from previous eye surgery not directly affecting the extraocular muscles, typically from prior glaucoma filtering surgery. The scar tissue must be dissected without disturbing the delicate balance of flow through the filtering bleb. This makes the procedure more intense than that of the single-muscle base codes, but not as intense as the two-muscle base codes including a muscle resection.

The RUC reviewed the survey results from 51 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 2.00 accurately reflects the physician work necessary to perform this service. The RUC recommends 15 minutes intra-service time for this add-on code. The intensity associated with this value (0.133) is appropriately intermediate between the single- and two-muscle base codes. It is almost identical to the intensity of CPT codes 67320 and 67334 at the recommended values. These three procedures are all similar in intensity and complexity.

The RUC compared CPT code 67331 to the top key reference code 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67331 is clearly considered more intense, with 100% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service and 21 minutes total time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67331 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.00 for CPT code 67331.**

67332 Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)

CPT code 67332 is an add-on procedure typically performed for patients with scarring of the extraocular muscles from previous surgery, trauma, or thyroid ophthalmopathy, typically from prior eye muscle surgery. The scar tissue must be identified and dissected, and the muscle isolated prior to proceeding with the base recession or resection procedure. In addition, the muscle is often inelastic and moved from its normal anatomic position. This is the most intense and complex of the add-on procedures in this family, similar in difficulty to a muscle resection and superior oblique surgery. The dissection is more difficult than that required for scarring that does not involve the extraocular muscles, CPT code 67331, and has a more profound effect on the outcome because it directly alters the muscle insertion anatomy and its effect on ocular motility.

The RUC reviewed the survey results from 53 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 3.50 accurately reflects the physician work necessary to perform this service. The RUC recommends 24 minutes intra-service time for this add-on code. The intensity associated with this value (0.146), is higher than that of any of the other add-on codes, maintaining an appropriate rank order within the ZZZ family. It is slightly less than that of the 2-muscle base codes (recession and resection), and almost identical to that of the superior oblique code, CPT code 67318. This places it in appropriate rank order amongst all the codes in the family.

The RUC compared CPT code 67332 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67332 is clearly considered more intense, with 85% of survey

respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared the survey code to CPT code 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 and total time) and noted that this comparator code is being recommended for the less difficult transposition procedure, CPT code 67320. CPT code 67332 is more work and should be valued higher than CPT code 67320 and its crosswalk code.

For additional support, the RUC referenced key MPC codes 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47, 45 minutes intra-service and total time) and 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67332 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.50 for CPT code 67332.**

67334 Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)

CPT code 67334 is an add-on procedure typically performed to alter the effect of a muscle recession by fixing the muscle to the sclera with an additional suture posterior to the muscle insertion, thereby avoiding the need for resection of a second muscle. This procedure is separate and additional to the base surgery. The typical patient is a child with esotropia. The location of the suture placement far posteriorly on the globe makes the procedure much more difficult, with increased risk of globe perforation, than that of the single-muscle base codes, but not as difficult as the two-muscle base codes requiring a resection.

The RUC reviewed the survey results from 46 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 2.06 accurately reflects the physician work necessary to perform this service. The RUC recommends 15 minutes intra-service time for this add-on code. The intensity associated with this value (0.137) is appropriately intermediate between the single- and two-muscle base codes. It is almost identical to the intensity of CPT codes 67320 and 67331 at the recommended values. These three procedures are all similar in intensity and complexity.

The RUC compared CPT code 67334 to the top key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is considerably higher than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67334 is clearly considered more intense, with 88% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared the survey code to CPT code 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*

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procedure) (work RVU = 3.00, 25 minutes intra-service and total time) and noted that this comparator code is being recommended for the less difficult transposition procedure, CPT code 67320. CPT code 67332 is more work and should be valued higher than CPT code 67320 and its crosswalk code.

For additional support, the RUC referenced key MPC codes *37253 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service and 21 minutes total time) and *36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67334 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.06 for CPT code 67334.**

67335 Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)

CPT code 67335 is performed as an add-on procedure to titrate the effect of the base code recession or resection procedure more precisely by allowing adjustment after completion of the base code procedure. An adjustable suture is placed intra-operatively. The adjustment is typically performed on the same day as the base procedure. It is typically done in the post-anesthesia care unit after sedation and local anesthesia have worn off, allowing assessment of alignment while the patient is awake and fixating. Although performed in the PACU, the adjustment procedure and final tying of the suture is an essential part of the intra-service work. There is no post-service work for this add-on code.

Unlike the other add-on codes in this family, CPT code 67335 was originally Harvard valued as a ZZZ and was not converted from a 090-day global, thus avoiding the clerical error that occurred in 1998. The changes at that time resulted in an anomalous relationship between this code and the other add-on procedures in the family. The anomalous relationship continued when the other add-on codes were converted from 090-day to ZZZ global and re-valued in 1998 using an MPPR calculation, while the value of CPT code 67335 was left unchanged. The MPPR methodology used to revalue the family in 1998 was flawed and is not considered acceptable today, as outlined in the compelling evidence argument.

The RUC reviewed the survey results from 35 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 3.23 accurately reflects the physician work necessary to perform this service. This is an increase from the current value of the code, as supported by compelling evidence and the robust survey results.

The RUC recommends 30 minutes intra-service time for CPT code 67335. This procedure requires more time than CPT codes 67320, 67331, 67332 or 67334, but is less intense. It does not require unusual muscle placement or dissection of scar tissue like those codes. However, it does take longer to place the suture and then adjust those sutures when the patient awakens. The intensity associated with this value (0.108) is lower than that of the other add-on codes in the family that have more difficult muscle insertion locations or require dissection of scar tissue. CPT code 67335 is of similar intensity to that of the one-muscle base codes and the other lengthy add-on code for a detached muscle, CPT code 67340.

The RUC compared CPT code 67335 to the top key reference code *14302 Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code* CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

for primary procedure) (work RVU = 3.73, 40 minutes intra-service and total time) and noted that the intra-service time is 10 minutes more than the survey code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67335 is considered more intense, with most survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

For additional support, the RUC referenced key MPC codes *36476 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65, 30 minutes intra-service and total time) and *63048 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* (work RVU = 3.47, 45 minutes intra-service and total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation.

The RUC concluded that CPT code 67335 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 3.23 for CPT code 67335.**

67340 Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)

CPT code 67340 is an add-on procedure typically performed for patients with a detached extraocular muscle. These are uncommon procedures, typically in young patients after prior ocular surgery or trauma. The muscle is typically retracted into the posterior orbit and must be found via a lengthy exploration prior to reattachment.

The RUC reviewed the survey results from 33 ophthalmologists and pediatric ophthalmologists and determined that the survey 25th percentile work RVU of 5.00 accurately reflects the physician work necessary to perform this service. The RUC recommends 45 minutes intra-service time for CPT code 67340. This procedure requires more time than CPT codes 67320, 67331, 67332 or 67334 but is less intense. It does not require unusual muscle placement or dissection of scar tissue like those codes. However, the exploration to locate the retracted muscle is lengthy. The intensity associated with this value (0.111) is lower than that of most of the other add-on codes in the family that have more difficult muscle insertion locations or require dissection of scar tissue. CPT code 67340 is appropriately like that of the single-muscle base codes and the other lengthy add-on code for an adjustable suture, CPT code 67335.

The RUC compared CPT code 67340 to the top key reference code *11008 Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and noted that the higher intra-service time for the key reference service is offset by the greater intensity of the survey code. CPT code 67340 is clearly considered more intense, with nearly 100% of survey respondents that selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code.

The RUC also compared the survey code to CPT code *22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes

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intra-service and total time) and noted that the codes have identical intra-service time and similar amount of physician work. The comparator code, however, yields an intensity closer to that of some of the more difficult codes in the family.

The RUC concluded that CPT code 67340 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 5.00 for CPT code 67340.**

Practice Expense

The Practice Expense Subcommittee accepted the spreadsheet for CPT codes 67311, 67312 67314, 67316 and 67318 without modification. No direct practice expense inputs are recommended for the ZZZ codes 67320, 67331, 67332, 67334, 67335 and 67340 as the practice expense for the add-on codes is already included in the base codes. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

Work Neutrality

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

X-Rays at Surgery Add-On – Tab 19

Curtis Anderson, MD, PhD (SIR); Lauren Golding, MD (ACR); Minhaj Khaja, MD (SIR); Charles Mabry, MD, FACS (ACS); Andrew Moriarity, MD (ACR); Kurt Schoppe, MD (ACR); Donald Selzer, MD (SAGES) and Ketan Sheth, MD (SAGES)

In October 2018, CPT codes 74300 and 74328 were identified via the CMS/Other Source codes with 2017e Medicare utilization over 30,000 screen. The RUC reviewed the specialty societies' action plan in which they said they would survey 74300 and 74328, along with 74329 and 74330 as part of this family of services in April 2019. On the action plan, the specialty societies also identified 74301 and recommended referral to CPT for deletion. The RUC recommended 74301 for deletion and the specialty societies submitted a CCA to delete CPT code 74301 at the February 2020 CPT meeting. However, the specialty societies withdrew the deletion request after receiving feedback from the dominant provider of 74301 (general surgery), indicating the code is still necessary and should not be deleted. The general surgeons noted that 74301 would be primarily reported by hepatobiliary surgeons who are using cholangiography to help identify the anatomy prior to, during, and after a resection of likely the extrahepatic biliary tree, liver and potentially pancreatic head. For example, the Frey and Beger procedures in which the head of the pancreas is cored out and the bile duct is preserved. Although intraoperative ultrasound is largely replacing cholangiography, as documented by decreasing utilization of 74301, ultrasound has not yet completely replaced cholangiography for evaluating the biliary and pancreatic system and code 74301 is still applicable to reporting a second cholangiogram, when medically necessary. Since code 74301 was not surveyed with the X-Ray Bile Ducts family in April 2019, it was scheduled for survey at the April 2020 RUC meeting. This issue was postponed until October 2020.

74301 Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)

The RUC recommends maintaining the work RVU of 0.21 for CPT code 74301. The RUC recommends 5 minutes of intra-service time and 1 minute of immediate post-service time. The specialty societies did not resurvey CPT code 74301 due to its low utilization (2019 Medicare utilization = 63) and the difficulty of obtaining 30 survey responses from providers with experience in the past 12 months. The RUC compared 74301 to 74300 *Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation* (April 2019 RUC recommended work RVU = 0.32). The RUC agreed with the specialty societies that add-on code 74301 will not require any additional pre-service work beyond the work

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required by the base code 74300. CPT code 74301 will require the same intra-service work and time as 74300, 5 minutes for the additional intraoperative cholangiography or pancreatography, and 1 minute to account for the physician work related to the report for the additional cholangiogram. The additional one minute is appropriate related to the two minutes required for 74300, which includes time for communicating results and recommendations that will not be duplicated. Based on comparison of the physician work and time for recently surveyed CPT code 74300, the RUC agreed that the current work RVU of 0.21 and total time of 6 minutes for CPT code 74301 is appropriate.

For additional support the RUC referenced CPT code 93352 *Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)* (work RVU = 0.19 and 5 minutes intra-service and total time) and CPT code 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)* (work RVU = 0.21 and 6 minutes intra-service time, 8 minutes total time). **The RUC recommends 0.21 work RVUs for CPT code 74301.**

Affirm RUC Recommendations

The RUC affirms its April 2019 work RVU recommendations of 0.32 for CPT code 74300, 0.47 for CPT code 74328, 0.50 for CPT code 74329 and 0.70 for CPT code 74330.

Practice Expense

CPT code 74301 is typically performed in the facility setting; thus, no direct practice expense inputs are recommended.

RUC Database Flag

The RUC will flag CPT code 74301 as “do not use for comparison” in the RUC database since the work RVU recommendation was not based on a survey.

External Cardiovascular Device Monitoring – Tab 20

Christopher Liu, MD (HRS); Mark Schoenfeld, MD, FHRs (HRS); David Slotwiner, MD, FHRs (HRS); Edward Tuohy, MD (ACC); Thad Waites, MD (ACC) and Richard Wright, MD (ACC)

In October 2019, the Relativity Assessment Workgroup identified codes 93228 and 93229 as part of their screen for services with Medicare utilization of 10,000 or more and a Medicare volume increase of at least 100% from 2013 through 2018e. In January 2020, the RUC recommended to review theses services at the October 2020 meeting.

93228 External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional

The RUC reviewed the survey results from 66 cardiologists and cardiac electrophysiologists and recommends the survey 25th percentile that maintains the current work RVU of 0.52 for CPT code 93228, the professional interpretation component only code. The RUC recommends 5 minutes pre-service evaluation time, 10 minutes intra-service time and 8 minutes post-service time. The 2 minute decrease in intra-service and overall time, relative to when this service was reviewed in 2008, is offset by an increase in the amount of data that the physician needs to review due to the increase in typical wear time.

The specialty societies noted that, since these services were last reviewed in 2008, there have been several changes in the technique and patient population. In the past, these monitors required 5 ECG stickers to be CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

placed across the precordium and connected to a relatively large recording device, which the patient wore on a strap over their shoulder. Batteries and ECG stickers were replaced by the patient as needed. The technique of monitoring now utilizes a much smaller adhesive patch with 2 electrodes (one at either end of the patch) and a small recording unit consisting of a computer and rechargeable battery that clips onto the patch. Patients switch the recording unit every 24 hours while one recharges. The substantially reduced size of these devices along with the simpler format has made it much easier for patients to wear the devices for longer periods of time. This has made it possible to now use these devices to evaluate stroke patients more effectively for possible occult paroxysmal atrial fibrillation as the etiology of their stroke. The specialty societies noted that the average wear time of these devices has increased since 2008 from 14 days to 20 days and provided literature from a study published in 2017 by Derkac Et Al as evidence of this assertion. It was noted that the amount of monitoring time has increased to an average of 20 days, which is likely due to both the reduced size/increased comfort of these newer units as well as the expanded indications of monitoring stroke patients for possible occult paroxysmal atrial fibrillation.

And with the average wear time increasing from 14 to 20 days, the number of ECG tracings as well as daily reports have also increased. This is offset by the fact that the technology has advanced to make it easier to manage and review the data, which accounts for the reduced intra-service time. The interface for physician interaction with the reports has moved from primarily a fax and paper-based system, which resulted in large amounts of paper reports to now more streamlined digital reports with data better organized and more easily accessible. At the same time, the number of episodes that the physician reviews and adjudicates have increased due to the increased wear time. The RUC agrees that the increased amount of data and the efficiency gained in reviewing that data offset each other.

To justify a work RVU of 0.52, the RUC compared the survey code to top key reference code 93298 *Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU= 0.52, intra-service time of 7 minutes, total time of 17 minutes) and noted that although the survey code involves more intra-service and total time, both services have a similar amount of physician work overall. The RUC also compared the survey code to MPC code 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU= 0.54, intra-service time of 10 minutes, total time of 22 minutes) and noted that both services typically involve identical intra-service time and the survey code typically involves one more minute of total time. Separately, the RUC also compared the survey code to its review of other external cardiac device monitoring codes for CPT 2021, including codes 93224, 93227, 93241, 93244, 93245 and 93248, and noted that a work value of 0.52 would have appropriate relativity and rank order with the CPT 2021 RUC recommendations for these other external cardiac device monitoring services. **The RUC recommends a work RVU of 0.52 for CPT code 93228.**

Practice Expense

93228 External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional

This code is a physician work interpretation code. The specialty societies indicated, however that clinical staff is necessary in the physician office to educate the patient regarding the role of mobile cardiovascular telemetry, the process for obtaining equipment and further instructions to be expected from the IDTF. Consistent with this recommendation, the RUC recommends 10 minutes of pre-service time for this clinical staff activity.

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93229 External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional

The specialty societies noted that the technical component for these services is typically outsourced to independent diagnostic testing facilities (IDTFs). One factor that makes these monitors distinct from other cardiac monitors is that, because they transmit telemetry throughout the wear period, they must be monitored 24/7 in order to provide the service and each company makes its own proprietary device. The technology at each company is different. The specialty societies worked with five of the largest suppliers of these services through an independent third-party consulting company to obtain practice expense data. The third-party company surveyed the providers of this service to collect, analyze and summarize the practice expense data. The specialty societies also discussed the technical component work with several IDTFs to clarify the practice expense work involved in performing this technical component only service. The specialty societies noted that the data does align with their direct patient care experience with other similar cardiac monitoring technologies. These data are included in the report provided by the third-party consulting company that provided detailed information on the types and durations of clinical staff time, supplies and equipment.

The Practice Expense (PE) Subcommittee discussed and accepted compelling evidence as there has been a substantial change in technology and a change in specialty. The patches are being worn now for multiple days, the devices are smaller, and the patient is being monitored for a much longer time than was the case in the early 2000s when this technology first appeared. The second compelling evidence criterion is a change in specialty from cardiologists providing the PE times and inputs to now directly collecting this data from the IDTFs.

The PE Subcommittee spent an extensive amount of time reviewing and discussing the clinical staff inputs with the specialty society presenters. The PE Subcommittee discussed the second clinical staff needed to over-read the individual arrhythmia events at the company before calling the cardiologist responsible for urgent or emergent arrhythmias. The Subcommittee confirmed that this over-reading is a clinical event and is separate from QA or QC activity and also that it is similarly separate and distinct from the activities of the cardiologists who also review the strips and information to validate the arrhythmia. The PE Subcommittee made some minor modifications to the clinical staff time after validating all the other clinical staff time inputs.

The PE Subcommittee validated that the invoices provided for the new MCT electrode patch kit did not include alcohol wipes and acetone wipes, putting them on and taking them off, nor the patient education booklet.

The PE Subcommittee also validated the minutes of equipment time. The specialty societies noted that the average wear time of these devices has increased since 2008 from 14 days to 20 days. They provided literature from a study published in 2017 by Derkac Et Al as evidence of this assertion. It was noted that the amount of monitoring time has increased to an average of 20 days likely due to both the reduced size/increased comfort of these newer units as well as the expanded indications of monitoring stroke patients for possible occult paroxysmal atrial fibrillation.

The RUC recommends the direct practice expense inputs for both 93228 and 93229 as modified by the Practice Expense Subcommittee.

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Approved by the RUC January 14, 2021

Updating CMS Inputs for EQ340 Patient Worn Telemetry System

The RUC noted that, due to the proprietary nature of the equipment, invoices were neither provided nor are achievable for updating the equipment item *EQ340 Patient Worn Telemetry System* which was last updated by CMS in 2008. The devices, which have experienced substantial improvements in technology since 2008, are proprietary devices owned and manufactured for each of the independent IDTFs. **The RUC recommends that CMS work directly with the IDTFs to determine the acquisition costs for the equipment item EQ340 Patient Worn Telemetry System.** CMS has experience with a similar situation where the Agency worked directly with a cardiac device manufacturer to attain the manufacturing costs and other proprietary information for a separate cardiac device.

CMS currently assigns *EQ340 Patient Worn Telemetry System* 3 years of useful life. The RUC notes that *EQ340* is the only equipment item and 93229 is the only CPT code with an equipment item that has more than 500 minutes of equipment time and a useful life of 3 years or less. All other equipment items which are assigned 500 or more minutes for any CPT code have a useful life of more than 3 years. **The RUC recommends that CMS work directly with the IDTFs to review the useful life for the equipment item EQ340 Patient Worn Telemetry System as it has not been updated since 2008 and the technology has substantially changed.**

Electrophysiologic Evaluation – REVISED – Tab 21

Richard Wright, MD (ACC); Thad Waites, MD (ACC); Christopher Liu, MD (HRS); David Slotwiner, MD (HRS); Edward Tuohy, MD (ACC) and Mark Schoenfeld, MD (HRS)

In October 2019, the RUC identified this service via the high-volume growth screen for services with Medicare utilization of 10,000 or more and have increased by at least 100% from 2013 through 2018. In January 2020, the RUC recommended this service be surveyed for April 2020. The code was surveyed individually, as it is not part of a specific family, because it is an add-on service that can be used with several different procedures - base codes or other add-on codes, diagnostic as well as therapeutic. The specialty societies appealed the April 2020 RUC recommendation based on a material procedural irregularity. The RUC granted the appeal and the specialty societies re-presented CPT code 93621 in October 2020.

93621 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 53 cardiologists and cardiac electrophysiologists and determined that a direct work RVU crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 1.75, 20 minutes intra-service and total time) would appropriately account for the physician work required to perform this service and falls below the survey 25th percentile.

The RUC discussed the decrease in intra-service time from 30 to 20 minutes and the accordant increase in intensity. Because the recommended work RVU is not an increase, a compelling evidence argument is not necessary. However, because of the change in calculated intensity that results from a decrease in intra-service time without an entirely commensurate decrease in work RVU, the specialty societies provided compelling evidence that there has been a change in technique that has changed physician work.

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Since 2001, when this code was last surveyed, there have been several changes in technique that have contributed to an increase in the intensity and decrease in the total time of the procedure. In particular, the typical access technique has evolved to the femoral vein to insert the catheter, as opposed to the jugular or subclavian vein. Previously, a superior vena cava (SVC) approach via internal jugular (IJ) or subclavian vein access was the preferred route to access the coronary sinus. Anatomically, this provides an ideal angle from which to cannulate the coronary sinus which sits at the inferior posteroseptal region of the right atrium, just above the tricuspid valve. This angle makes it possible to use a simple fixed curve catheter and ensures that the catheter position will remain stable throughout the procedure. The downside of the superior approach is that it requires an additional access site (the internal jugular or subclavian vein) that would otherwise not be needed. This carries a small but real risk of pneumothorax and the IJ / subclavian access site can be uncomfortable for patients during and after the procedure. For these reasons, most electrophysiologists have evolved their practice and now use a femoral vein approach to deploy the coronary sinus catheter.

The femoral approach avoids the need to prep and drape an additional access site since the other sheaths and catheters for EP studies are also placed from a femoral approach. However, a separate and additional sheath needs to be inserted into the femoral vein for placement of the coronary sinus catheter. Due to the need for multiple sheaths in the same femoral vein access region, care must be taken during venous access to space the access sites sufficiently to avoid interference between the catheters. In addition, a femoral venous approach introduces anatomical challenges for cannulating the coronary sinus and does not provide the natural stability of the catheter achieved from a subclavian approach. The primary anatomical obstacles are the height of the eustachian ridge/inferior vena cava junction and the abrupt reverse angle (usually greater than 135 degrees) that the catheter must traverse once it passes above the eustachian ridge in order to enter to coronary sinus ostium. With the advent of manually deflectable catheters, electrophysiologists are usually (but not always) able to cannulate the coronary sinus from a femoral approach despite the anatomical challenges. However, because the anatomy (eustachian ridge/IVC junction) intrinsically puts pressure on the catheter in a direction that pulls it away from the coronary sinus, the catheter is much less stable than it would be from a superior approach. As a result, it is typical for the coronary sinus catheter to become dislodged multiple times in a single case requiring the operator to reposition the catheter each time.

The RUC agreed that the minutes reduced from the change in access site are at the lower end of the intensity spectrum for the service, which naturally leads to an increase in calculated intensity that is compounded by the increased intensity of making the turn at the IVC/eustachian ridge and multiple re-positionings of the catheter.

Another difference from 2001 is that this service is typically added on to EP-studies performed in concert with ablation therapies, rather than with diagnostic-only EP studies as was predominant in 2001. Medicare reported together data show that these services are now typically performed as a combination of therapeutic and diagnostic interventions (e.g., EP ablation), as opposed to simply diagnostic procedures. The survey add-on code is most often reported with ablation code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 14.75, 180 minutes intra-service time) and diagnostic code 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* (work RVU = 5.23, 90 minutes intra-service time). Specifically, the data shows that approximately 80% of 93621 is reported with CPT code 93653. The placement of a catheter for pacing/recording in the left atrium and coronary sinus is more complex/intense in an ablation CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association

versus a diagnostic procedure. Patients who proceed to ablative therapies are more complex than those only receiving diagnostic catheterization.

Moreover, the RUC notes that while it is uncommon for an add-on code to be more intense than the underlying service, it does occur, and it is common in the electrophysiology space. A relevant example is trans-septal puncture CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)* (work RVU = 3.73, 40 minutes intra-service and total time) that may be performed with SVT ablation CPT code 93653 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry (List separately in addition to code for primary procedure)* (work RVU = 14.75, 180 minutes intra-service and 239 minutes total time). The ablation procedure intensity is 0.075 while the puncture is more intense at 0.093. An intensity of 0.088 from the RVU recommendation for CPT code 93621 fits this model and is a reasonable intensity rank order.

The RUC compared CPT code 93621 to the second highest key reference service and MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25, 30 minutes intra-service and total time) and noted the intra-service time is 10 minutes less for the survey code and all the survey respondents that selected the second key reference code rated the survey code as more intense and complex overall relative to the reference code.

The RUC also identified CPT code 37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80, 20 minutes intra-service time and 22 minutes total time) for comparison purposes and noted that the comparator code has the same amount of intra-service time and intensity as the survey code.

For additional support, the RUC referenced key MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44, 20 minutes intra-service time and 1 minute immediate post-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and noted that the multi-specialty points of comparison codes appropriately bracket the survey code. The RUC further noted that there are 12 RUC reviewed ZZZ codes with 20 minutes intra-service time and work values between 1.40 and 2.00.

The RUC concluded that, given changes in intensity and total time for the procedure, CPT code 93621 should be valued based on a direct work RVU crosswalk to CPT code 36483 with 20 minutes intra-service time as supported by the survey. **The RUC recommends a work RVU of 1.75 for CPT code 93621.**

Practice Expense

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CPT code 93621 is provided exclusively in the facility setting; thus, no direct practice expense inputs are recommended.

Work Neutrality

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

XI. Research Subcommittee (Tab 22)

Doctor Ezequiel Silva, Chair, provided the report of the Research Subcommittee:

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

The Research Subcommittee report from the June 2nd conference call and separate electronic review included in Tab 22 of the October 2020 agenda materials were approved without modification.

- **Pre-service Evaluation IPUT input and WPUT**

During the RUC's Other Business discussion at the April 2019 RUC meeting, a RUC member questioned whether the Harvard-based pre-service evaluation time intensity input in the Intra-service Work Per Unit of Time (IPUT) formula remains correct. The member pointed out that when considering the compelling evidence for the office visits codes, the IPUT for the pre-service evaluation time was higher than the previously standardized value of 0.0224. The volume-weighted work per unit of time (WPUT) of the RUC's May 2019 office visit recommendation was 0.0409. The member asked if the same increase in work may apply to the pre-service evaluation component of other services. The RUC agreed to refer the issue to the Research Subcommittee for consideration.

At previous meetings, the Subcommittee has noted that the pre-evaluation evaluation, pre-service positioning and immediate post-service components of the IPUT formula have a "standardized" value for IPUT of 0.0224, resulting from phase 2 and phase 3 of the Harvard studies. Subcommittee members noted that the intensity input of 0.0224 has remained in place for over 25 years. The ongoing discussion has had two separate, but related considerations: (1) the addition of Work per Unit Time (WPUT) as an additional metric for code valuation; (2) potentially modernizing the IPUT formula used in code valuations.

The Subcommittee continued its discussion related to work per unit of time (WPUT). A Subcommittee member shared their observation that for very short procedures (e.g. less than 10 minutes of total time), the IPUT metric becomes less reliable. They suggested that the work per unit time metric may be particularly useful when evaluating these services. As was the case at previous meetings, many Subcommittee members expressed support for WPUT being used as a separate metric in addition to IPUT. In response to a Subcommittee request in April, AMA staff had prepared a draft update to the summary spreadsheet with a WPUT column for the Subcommittee's consideration. The Subcommittee updated the draft proposed template by relocating the Work per Unit of Time Column immediately to the right of the existing IPUT column. **The Research Subcommittee recommends for the RUC summary spreadsheet template to be updated to add Work per Unit of Time immediately to the right of the IPUT column in the spreadsheet (column G).**

Continuing their discussion from the April 2020, on the July 2020 conference call, the Subcommittee affirmed that the intent of their discussion of the IPUT formula is not to prompt retroactive

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systematic valuation changes to existing codes, but solely to potentially modernize the IWPUT formula. For the July meeting, AMA Staff again provided the Subcommittee with an analysis which included the current (2020) volume weighted WPUT and IWPUT for each section of the CPT book, as well as each global period. The analysis also modeled several scenarios replacing the 0.0224 intensity with either 0.04 (the WPUT intensity from the April 2019 Office Visit recommendations) or an intensity of 0.03 (selected arbitrarily for illustrative purposes by AMA staff as an intensity partway between the current intensity and the Office visit intensity.) The Subcommittee noted that replacing the 0.0224 input in the IWPUT formula with a higher value would result in additional CPT codes having a negative IWPUT which is also one of the RUC's criteria for achieving the compelling evidence standard.

A Subcommittee member proposed to both retain the current version of the IWPUT formula and permit societies to optionally include a clearly labeled alternate IWPUT datapoint in the additional rationale section of the Summary of Recommendation (SOR) word document. For surgical services, this would only involve replacing the pre-service evaluation and immediate post-service inputs in the IWPUT formula with 0.04 instead of 0.0224. The Subcommittee agreed to this proposal and noted that pre-service scrub/dress/wait time should remain at 0.0081 and pre-service positioning should remain at 0.0224 in this alternate IWPUT formula since positioning time and scrub/dress/wait time are disparate from E/M work. For non-surgical services (which do not break out pre-service time into multiple subcomponents), the IWPUT formula input for pre-service time and post-service time would be replaced by 0.04 for this alternate IWPUT formula.

The Research Subcommittee recommended to allow specialty societies the option of including a clearly labeled alternate IWPUT data point in the additional rationale section of the Summary of Recommendation (SOR) word document form for all services. Specifically, for surgical services, this would involve replacing only the pre-service evaluation and immediate post-service intensity inputs in the IWPUT formula with 0.04 instead of 0.0224. For non-surgical services (which do not breakout pre-service time into subcomponents and do not include bundled post-operative visits), this would involve replacing the IWPUT intensity input for pre-service and post-service time with 0.04. The Subcommittee agreed to evaluate this new policy in two years.

- Presentation and Discussion Format for Review of Specialty Requests**

On the February 2020 Subcommittee call, the Chair referred an issue for discussion at a future meeting to consider whether any changes to Research Subcommittee presentation and discussion format for review of specialty requests would be warranted. Currently, assigned Subcommittee reviewers initiate the discussion, raise questions, and make recommendations. The rest of the Subcommittee then could provide comments and raises questions. Then, society advisory committee members respond. On the July call, the Subcommittee considered an alternative approach where each advisory committee would first provide an introductory presentation at the beginning of their tab, including a brief overview of what the services are that are under review, what they are requesting from research and a general rationale to support their proposal. Following that brief introduction, the assigned reviewers could then provide their feedback. Overall, Subcommittee members supported this change in presentation and discussion format, though agreed that the advisory committee introduction should be concise. **The Research Subcommittee agreed to try the new presentation format at the next meeting where applicable, whereby each advisory committee would first give a brief introductory presentation at the beginning of their tab and following that initial presentation, the assigned Subcommittee reviewers and the other Subcommittee could provide their feedback and discuss how to respond to the specialty request.**

- **Vignette Format for Anesthesia Codes**

During review of a proposed anesthesia vignette on the February 2020 call, the American Society of Anesthesiologists (ASA) presenters noted that the precedent for anesthesia vignettes has been to use the same vignette as the most commonly reported surgical code on the same day as the anesthesia service (excluding unrelated services), which was recently validated by the RUC Anesthesia Workgroup. ASA had also proposed to include an additional sentence to concisely state what specific surgical service was typically being performed with the anesthesia service. The Subcommittee had agreed to that change for that one code on the February call and agreed to discuss at an upcoming meeting whether a precedent should be set for the general vignette format for all Anesthesia services.

The Research Subcommittee agreed that the beginning of the vignette for each anesthesia service should be identical to the vignette of the most commonly reported surgical code on the same day as the anesthesia service (excluding unrelated services), as has been the long-standing precedent. The Subcommittee also agreed that adding an additional sentence to describe the surgical procedure would be appropriate, as without this added context, the anesthesiologist survey respondent would not be informed of the additional helpful information regarding the typical surgical procedure. An ASA representative on the call confirmed their society's support for this new vignette format, as it aligned with what the society had proposed on the February 2020 Research conference call. **The Subcommittee recommends that going forward, Anesthesia services vignettes should continue to be formatted so the beginning of the vignette would be identical to the vignette of the most commonly reported surgical code on the same day as the anesthesia service (excluding unrelated services), though with an additional sentence to describe the surgery that is typically being performed with the anesthesia service.**

- **Informational – Research Subcommittee Guidelines & Requirements Document**

The Subcommittee discussed the current version of the Research Subcommittee Guidelines & Requirements document and agreed that overall, the document is very helpful for specialty societies. A Subcommittee member recommended **The Research Subcommittee recommends the following change:**

- **For the instructions on appropriate formatting for an RSL proposal to be revised for IV.a.iv.6 to “Whether the time is based on RUC, RUC-CMS Revised, Harvard or other.”**

Separately, AMA Staff noted that they could include helpful links to other documentation within the document and the Subcommittee agreed that would be appropriate.

- **Specialty Request Regarding Strabismus Surgery Add-on Procedures**

At the time of the July Research Subcommittee policy call, the American Academy of Ophthalmology (AAO) was in the process of surveying a family of codes for strabismus surgery. The specialty society representatives shared with the Subcommittee that several of their RUC survey respondents indicated to the society that one or more of the strabismus add-on codes typically include post-operative visits beyond those already included in the base codes. The presenters noted that their expert panel concurred with that assessment. Therefore, AAO drafted a custom follow-up survey to be shared with the strabismus surgery survey respondents. The questions in the survey shall assess whether the ZZZ codes should include bundled visits and the specialties requested approval from the Research Subcommittee to distribute this follow-up survey. The intent of the survey is to assess whether survey respondents typically perform additional post-op visits when a 090-day surgical code is accompanied by an add-on surgical code compared to when that base 090-day surgical code is performed alone. AAO noted they had used the standard ZZZ template for this survey which does not inquire about bundled post-operative visits. AMA staff noted that there is precedent for bundling visits in add-on ZZZ codes as there are 11 cardiothoracic ZZZ codes with post-operative visits which were RUC reviewed between 2005 and 2007.

The AAO presenter explained that they are proposing this follow-up survey method, as opposed to requiring respondents redo the entire survey, to avoid being overly burdensome on their survey respondents. They noted that the response rate would likely be lower for a full RUC survey of the same codes over again. A Subcommittee member inquired whether the AAO custom follow-up survey instrument should also include the level of the visits and the AAO advisor noted that they believe any indicated visits would be a level 2 visit. Therefore, asking the specific level of visit would be unnecessary.

Many Subcommittee members noted they were understanding of the current situation and acknowledged that there are merits and drawbacks to taking either approach (a follow-up survey versus completely redoing the survey with a new ZZZ with visit template). Overall, the Subcommittee agreed that, for what the custom follow-up survey is intended to do, the proposed language is appropriate and did not have any suggested revisions. A Subcommittee member cautioned that although they are do not object to approving the custom follow-up survey as proposed by AAO, the level of detail that would be collected and the unprecedented nature of the follow-up survey methodology could put the specialty at a disadvantage.

The Research Subcommittee approved the proposed custom follow-up survey template as proposed by AAO and noted that the advisory committee may choose either to use this follow-up survey approach or conduct a full RUC survey with the ZZZ with visit template.

The RUC approved the Research Subcommittee Report.

XII. Relativity Assessment Workgroup (Tab 23)

Doctor Margie Andreeae, Chair, provided a summary of the Relativity Assessment Workgroup recommendations. The Workgroup reviewed action plans for 33 codes that were identified as part of 16 families by five different screens.

Identified via the new technology/new services screen, the Workgroup recommends surveying the family of the Complex Chronic Care Coordination Services and Chronic Care Management codes (99487, 99489, 99490) along with the Principal Care Management code in January 2021.

The Workgroup recommends to survey code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* along with the appropriate family of codes for January 2021. Code 27446 was identified by the site of service anomaly screen in which this service is typically performed in the outpatient setting yet includes inpatient hospital visits.

The Workgroup recommends that CPT code 73580 be referred to CPT to be bundled with CPT code 27369 *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography*.

Doctor Andreeae noted that 8 families will be reviewed again when more data is available. Lastly, 22 codes were identified by re-running the screens based on the most recent data and the Workgroup will review action plans for these codes in January 2021.

The RUC approved the Relativity Assessment Workgroup Report.

XIII. Practice Expense Subcommittee (Tab 24)

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

000 and 010 Day Global Pre-Service Time Workgroup

The PE Subcommittee discussed the pre-service clinical staff time (CA001-CA005) related to changes in global periods. The Subcommittee acknowledged that there are several existing standard time packages which should be used as a starting point to develop pre-service time recommendations and questioned the use of global periods as a “surrogate” for the complexity of pre-service clinical needs. It was noted that the existing pre-service clinical staff time standards have been reviewed multiple times, most recently in early 2020 when the PE Subcommittee formed a 000 and 010 Day Global Pre-Service Time Workgroup to compile data on 000 and 010-day pre-service clinical staff time, identify services that are major surgeries and validate that the pre-service time is appropriate. This Workgroup reported back in April 2020 and the PE Subcommittee recommended no change to the current pre-service clinical staff time for individual codes with 000 and 010 day global periods.

The PE subcommittee recommended that once again a workgroup be formed to address the nuance of what to do with 90-day globals that change to 000 or 10 day and how the standard clinical labor pre-time packages should be handled for these codes with global changes that are still major surgical procedures.

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The Chair recommended that the deliberations from the previous workgroup and earlier workgroups developing the various pre-service clinical staff time packages serve as a basis for this effort. **The RUC agreed that it is appropriate to form a PE Workgroup to consider how changes in global periods from 90 day to 000 or 010 day are handled with regard to pre-service clinical staff time.** This is a separate issue than how to handle budget neutrality when switching global period, which Research will discuss at the April meeting.

Injection Packs

The PE Subcommittee discussed the use of injection packs and the need for substitutions and additional line items as was seen with Tab 17 Destruction by Neurolytic Agent. The subcommittee specifically discussed the specialties' use of SA041 *pack, basic injection* which includes 10 ml povidone solution (Betadine) and the addition of SJ081 *swab, patient prep, 1.5 ml (chloraprep)*. It was suggested that the use of Betadine is no longer typical. **The PE Subcommittee determined that staff should identify those codes that use Betadine and inquire of the appropriate specialties whether they should be revised.** This task led to a larger discussion of packs: both "virtual" packs assigned as placeholders by the subcommittee and commercially produced packs/kits. A member suggested to include a question on the PE SOR to delineate whether a pack is virtual or commercial. Further discussion emphasized the need for "guardrails" to justify when additional supply items are added and to avoid reverting to having line items for every supply. Also, there may be a need for a "pack update process." **For all these reasons, the PE Subcommittee recommended that a Workgroup be formed to consider revisions in the injection packs and in how to address individual items for the packs.**

Time-Outs in Pre-Service Time

The PE Subcommittee discussed whether the required use of time-outs is currently accounted for in pre-service clinical time. A member stated that time-outs are universal for invasive procedures so we have not included additional time. However, there are currently codes in the database that include time-out in the pre-service description of work. Another member questioned whether the "wait" time in Scrub/Dress/Wait accounts for time-outs in other codes. Finally, there was recognition that the time-outs are indeed additive time for yet other codes. **The PE Subcommittee determined that the issue of time-outs in pre-service time should first be discussed at the RUC meeting in the context of physician work.**

The RUC approved the Practice Expense Subcommittee Report.

XIV. New/ Other Business

RUC Seat Request

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) submitted a letter to request the creation of a permanent seat on the RUC for the specialty of Physical Medicine & Rehabilitation. AAPM&R currently holds a rotating seat on the RUC, filled by Doctor Matthew Grierson, whose two-year term began in March 2019. The specialty society indicated that the following criteria for consideration of a permanent RUC seat have been met to be considered by the RUC:

- The specialty is an American Board of Medical Specialties (ABMS) specialty;
- The specialty comprises at least 1 percent of physicians in practice;
- The specialty comprises at least 1 percent of physician Medicare expenditures;
- Medicare revenue is at least 10 percent of mean practice revenue for the specialty;

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- The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.

Doctor Edward Vates, Chair of the Administrative Subcommittee, made the motion and the **RUC agreed to refer AAPM&R's request to create a permanent seat on the RUC to the Administrative Subcommittee to further review this request.**

Request for Global Period Change Workgroup

A RUC member requested that the RUC Chair appoint a new workgroup to develop policy and procedure recommendations for the RUC regarding how neutral evaluation of codes undergoing a change in global period should be best accomplished and broadly representative.

The RUC Chair recommended for this issue to be referred to the Research Subcommittee for further discussion. Currently, there is no formal transition underway, global period changes have been due to specific requests from the specialty society who is surveying the code(s). Global period changes were not requested by CMS, they were requested by the specialty society who performs these services. Currently, there is no formal policy to change global periods.

The RUC agreed to refer this request to the Research Subcommittee to review global period changes and its effect on the evaluation of services.

The RUC adjourned at 10:48 a.m. on Saturday, October 10, 2020.

Members Present: Ezequiel Silva III, MD (Chair), Jimmy Clark, MD (Vice Chair), Dale Blasier, MD, Gregory DeMeo, MD, Peter Hollmann, MD, Omar Hussain, MD, Katie Jordan, OTD, OTR/L, M. Douglas Leahy, MD, Eileen Moynihan MD, Guy Orangio, MD, Marc Raphaelson, MD, Stanley Stead, MD, Timothy Tillo, DPM, David Yankura, MD, Robert Zwolak, MD

I. Minutes, June 2nd RSC Specialty Requests Conference Call and Subsequent Electronic Review

The Research Subcommittee approved the report from the June 2nd conference call included in Tab 22 of the October 2020 agenda materials were approved without modification.

II. Pre-service Evaluation IWPUT input and WPUT

During the RUC's other business discussion at the April 2019 RUC meeting, a RUC member questioned whether the Harvard-based pre-service evaluation time intensity input in the Intra-service Work Per Unit of Time (IWPUT) formula remains correct. The member pointed out that when considering the compelling evidence for the office visits codes, the IWPUT for the pre-service evaluation time was higher than the previously standardized value of 0.0224. The volume-weighted work per unit of time (WPUT) of the RUC's May 2019 office visit recommendation was 0.0409. The member asked if the same increase in work may apply to the pre-service evaluation component of other services. Separately, a RUC member had requested for the Research Subcommittee to explore whether the RUC should consider more routinely reviewing Work per unit Time (WPUT) in addition to IWPUT. The RUC agreed to refer these issues to the Research Subcommittee for consideration — the Research Subcommittee has had an ongoing discussion on both topics over several meetings.

At previous meetings, the Subcommittee has noted that the pre-evaluation evaluation, pre-service positioning and immediate post-service components of the IWPUT formula have a “standardized” value for IWPUT of 0.0224, resulting from phase 2 and phase 3 of the Harvard studies. Subcommittee members noted that the intensity input of 0.0224 has remained in place for over 25 years. The ongoing discussion has had two separate, but related considerations: (1) the addition of Work per Unit Time (WPUT) as an additional metric for code valuation; (2) potentially modernizing the IWPUT formula used in code valuations.

The Subcommittee continued its discussion related to work per unit of time (WPUT). A Subcommittee member shared their observation that for very short procedures (e.g. less than 10 minutes of total time), the IWPUT metric becomes less reliable. They suggested that the work per unit time metric may be particularly useful when evaluating these services. As was the case at previous meetings, many Subcommittee members expressed support for WPUT being used as a separate metric in addition to IWPUT. In response to a Subcommittee request in April, AMA staff had prepared a draft update to the summary spreadsheet with a WPUT column for the Subcommittee's consideration. The Subcommittee updated the draft proposed template by relocating the Work per Unit of Time Column immediately to the right of the existing IWPUT column. **The Research Subcommittee recommends for the RUC summary spreadsheet template to be updated to add Work per Unit of Time immediately to the right of the IWPUT column in the spreadsheet (column G).**

Continuing their discussion from the April 2020, on the July 2020 conference call, the Subcommittee affirmed that the intent of their discussion of the IWPUT formula is not to prompt retroactive systematic

valuation changes to existing codes, but solely to potentially modernize the IWPUT formula. For the July meeting, AMA Staff again provided the Subcommittee with an analysis which included the current (2020) volume weighted WPUT and IWPUT for each section of the CPT book, as well as each global period. The analysis also modeled several scenarios replacing the 0.0224 intensity with either 0.04 (the WPUT intensity from the April 2019 Office Visit recommendations) or an intensity of 0.03 (selected arbitrarily for illustrative purposes by AMA staff as an intensity partway between the current intensity and the Office visit intensity.) The Subcommittee noted that replacing the 0.0224 input in the IWPUT formula with a higher value would result in additional CPT codes having a negative IWPUT which is also one of the RUC's criteria for achieving the compelling evidence standard.

Several Subcommittee members have noted that surgical pre-service evaluation time and immediate post-service time is analogous to E/M as it is face-to-face, the surgeon has to focus solely on the patient during that time and that the intensity is similar to E/M for several of the components. They noted that, during pre-service evaluation, the surgeon is performing face-to-face E/M work and that it would be appropriate for that component to have a similar intensity to separately reported E/M services. Some of the Subcommittee concurred with this assessment and noted that it would be a strong rationale for changing the IWPUT formula input of 0.0224 to 0.04, whereas others concurred with the general logic though expressed reservation with completely changing the current IWPUT formula and noted that a complete replacement of the IWPUT formula would need to be proposed to CMS and presumably subject to public comment through rulemaking.

A Subcommittee member proposed to both retain the current version of the IWPUT formula and permit societies to optionally include a clearly labeled alternate IWPUT datapoint in the additional rationale section of the Summary of Recommendation (SOR) word document. For surgical services, this would only involve replacing the pre-service evaluation and immediate post-service inputs in the IWPUT formula with 0.04 instead of 0.0224. The Subcommittee agreed to this proposal and noted that pre-service scrub/dress/wait time should remain at 0.0081 and pre-service positioning should remain at 0.0224 in this alternate IWPUT formula since positioning time and scrub/dress/wait time are disparate from E/M work. For non-surgical services (which do not break out pre-service time into multiple subcomponents), the IWPUT formula input for pre-service time and post-service time would be replaced by 0.04 for this alternate IWPUT formula.

The Research Subcommittee recommended to allow specialty societies the option of including a clearly labeled alternate IWPUT data point in the additional rationale section of the Summary of Recommendation (SOR) word document form for all services. Specifically, for surgical services, this would involve replacing only the pre-service evaluation and immediate post-service intensity inputs in the IWPUT formula with 0.04 instead of 0.0224. For non-surgical services (which do not breakout pre-service time into subcomponents and do not include bundled post-operative visits), this would involve replacing the IWPUT intensity input for pre-service and post-service time with 0.04. The Subcommittee agreed to evaluate this new policy in two years.

III. Presentation and Discussion Format for Review of Specialty Requests

On the February 2020 Subcommittee call, the Chair referred an issue for discussion at a future meeting to consider whether any changes to Research Subcommittee presentation and discussion format for review of specialty requests would be warranted. Currently, assigned Subcommittee reviewers initiate the discussion, raise questions, and make recommendations. The rest of the Subcommittee then could provide comments and raises questions. Then, society advisory committee members respond. On the July call, the Subcommittee considered an alternative approach where each advisory committee would first provide an introductory presentation at the beginning of their tab, including a brief overview of what the services are that are under review, what they are requesting from research and a general rationale to support their proposal. Following

that brief introduction, the assigned reviewers could then provide their feedback. Overall, Subcommittee members supported this change in presentation and discussion format, though agreed that the advisory committee introduction should be concise. **The Research Subcommittee agreed to try the new presentation format at the next meeting where applicable, whereby each advisory committee would first give a brief introductory presentation at the beginning of their tab and following that initial presentation, the assigned Subcommittee reviewers and the other Subcommittee could provide their feedback and discuss how to respond to the specialty request.**

IV. Vignette Format for Anesthesia Codes

During review of a proposed anesthesia vignette on the February 2020 call, the American Society of Anesthesiologists (ASA) presenters noted that the precedent for anesthesia vignettes has been to use the same vignette as the most commonly reported surgical code on the same day as the anesthesia service (excluding unrelated services), which was recently validated by the RUC Anesthesia Workgroup. ASA had also proposed to include an additional sentence to concisely state what specific surgical service was typically being performed with the anesthesia service. The Subcommittee had agreed to that change for that one code on the February call and agreed to discuss at an upcoming meeting whether a precedent should be set for the general vignette format for all Anesthesia services.

The Research Subcommittee agreed that the beginning of the vignette for each anesthesia service should be identical to the vignette of the most commonly reported surgical code on the same day as the anesthesia service (excluding unrelated services), as has been the long-standing precedent. The Subcommittee also agreed that adding an additional sentence to describe the surgical procedure would be appropriate, as without this added context, the anesthesiologist survey respondent would not be informed of the additional helpful information regarding the typical surgical procedure. An ASA representative on the call confirmed their society's support for this new vignette format, as it aligned with what the society had proposed on the February 2020 Research conference call. **The Subcommittee recommends that going forward, Anesthesia services vignettes should continue to be formatted so the beginning of the vignette would be identical to the vignette of the most commonly reported surgical code on the same day as the anesthesia service (excluding unrelated services), though with an additional sentence to describe the surgery that is typically being performed with the anesthesia service.**

V. Informational – Research Subcommittee Guidelines & Requirements Document

The Subcommittee discussed the current version of the Research Subcommittee Guidelines & Requirements document and agreed that overall, the document is very helpful for specialty societies. A Subcommittee member recommended **The Research Subcommittee recommends the following change:**

- **For the instructions on appropriate formatting for an RSL proposal to be revised for IV.a.iv.6 to “Whether the time is based on RUC, RUC-CMS Revised, Harvard or other.”**

Separately, AMA Staff noted that they could include helpful links to other documentation within the document and the Subcommittee agreed that would be appropriate.

VI. Specialty Request Regarding Strabismus Surgery Add-on Procedures

The American Academy of Ophthalmology (AAO) is in the process of surveying a family of codes for strabismus surgery. The specialty society representatives shared with the Subcommittee that several of

their RUC survey respondents indicated to the society that one or more of the strabismus add-on codes typically include post-operative visits beyond those already included in the base codes. The presenters noted that their expert panel concurred with that assessment. Therefore, AAO drafted a custom follow-up survey to be shared with the strabismus surgery survey respondents. The questions in the survey shall assess whether the ZZZ codes should include bundled visits and the specialties requested approval from the Research Subcommittee to distribute this follow-up survey. The intent of the survey is to assess whether survey respondents typically perform additional post-op visits when a 090-day surgical code is accompanied by an add-on surgical code compared to when that base 090-day surgical code is performed alone. AAO noted they had used the standard ZZZ template for this survey which does not inquire about bundled post-operative visits. AMA staff noted that there is precedent for bundling visits in add-on ZZZ codes as there are 11 cardiothoracic ZZZ codes with post-operative visits which were RUC reviewed between 2005 and 2007. AMA staff also noted that there is a standard ZZZ with visits survey template and that template was included as a reference (Research agenda materials document 6D).

The AAO presenter explained that they are proposing this follow-up survey method, as opposed to requiring respondents redo the entire survey, to avoid being overly burdensome on their survey respondents. They noted that the response rate would likely be lower for a full RUC survey of the same codes over again. A Subcommittee member inquired whether the AAO custom follow-up survey instrument should also include the level of the visits and the AAO advisor noted that they believe any indicated visits would be a level 2 visit. Therefore, asking the specific level of visit would be unnecessary.

Some Subcommittee members noted that, optimally if survey fatigue was not a consideration, the survey respondents would be required to complete the standard RUC ZZZ with visit survey template; the Subcommittee members acknowledged the tradeoff between taking that lengthier approach versus conducting a more focused follow-up survey as AAO was proposing. Another Subcommittee member expressed concern with the lack of precedent for using a follow-up survey of this nature and noted that they were unsure whether or not this format could potentially be leading or potentially not be representative due to the likelihood of not all original survey respondents participating in the follow-up survey.

Many Subcommittee members noted they were understanding of the current situation and acknowledged that there are merits and drawbacks to taking either approach (a follow-up survey versus completely redoing the survey with a new ZZZ with visit template). Overall, the Subcommittee agreed that, for what the custom follow-up survey is intended to do, the proposed language is appropriate and did not have any suggested revisions. A Subcommittee member cautioned that although they are do not object to approving the custom follow-up survey as proposed by AAO, the level of detail that would be collected and the unprecedented nature of the follow-up survey methodology could put the specialty at a disadvantage.

The Research Subcommittee approved the proposed custom follow-up survey template as proposed by AAO and noted that the advisory committee may choose either to use this follow-up survey approach or conduct a full RUC survey with the ZZZ with visit template.

Members Present: Doctors Margie Andreea (Chair), Norman Smith (Vice Chair), Jeffrey Paul Edelstein, Matthew Grierson, Gregory Harris, John Heiner, David Hitzeman, Timothy Laing, Lance Manning, Alan Lazaroff, Charles Mabry, Dee Adams Nikjeh, PhD, CCC-SLP, Folusho Ogunfiditimi, PA-C, John Proctor and David Wilkinson.

I. CMS High Expenditure Procedural Codes (75710)

In the NPRM for 2016, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In October 2016, the RUC noted that with the newly bundled dialysis access maintenance codes that were approved in January 2016 as part of Dialysis Circuit code family 36901-36909, the specialties project that a significant portion of the nephrology volume for CPT code 75710 will instead be reported with applicable Dialysis Circuit codes. Nephrology represented 18% of the 2015 Medicare claims (global & -26 modifier) for 75710. The RUC added a flag for review to confirm that Nephrology utilization volume has decreased once 2017 Medicare utilization data was available for review. In October 2018, the RUC noted the Nephrology utilization was slightly decreasing to 14% (global & -26 modifier) and to review utilization again in two years (2020).

The Workgroup reviewed the history of this code and the action plan submitted by SVS, SIR, ACR and ACC. Noting that the 2019e utilization by nephrologists is gradually decreasing (13%) (global & -26 modifier). The Workgroup questioned if the gradual decrease in utilization by nephrologists is appropriate or if nephrologists should not be performing this service at all. The Workgroup noted that RPA was not involved in the development of this action plan. **The Workgroup requests the input from Nephrology regarding the reporting of CPT code 75710 and review at the January 2021 Relativity Assessment Workgroup meeting.**

II. Contractor Priced High Volume (90867-90869)

In January 2018, a RUC member suggested to review high volume contractor priced codes. CPT code 90868 was identified as a contractor-priced Category I code with 2017 estimated Medicare utilization over 10,000. The Workgroup determined that there are various reasons in which these codes have been recommended to be contractor priced and the specialty societies should submit action plans for the October 2018 meeting indicating whether these services should be reviewed for physician work/practice expense by the RUC. In October 2018, the RUC noted that these services (90867, 90868 and 90869) are also identified on the new technology list for review. The Workgroup agreed with the specialty that technology for these services is still evolving. Two FDA modifications were recently approved, and the new coil will significantly reduce the time required to perform these services. The RUC recommended these services be reviewed again in two years (2020).

The Workgroup noted that this issue is also under review at this meeting via the new technology/new services screen. The Workgroup agreed that the CMS practice expense methodology issues as the specialty society outlined in their action plan still exist. The coil technology continues to change with treatment for depression and OCD, which involve different equipment. The codes continue to grow exponentially, especially CPT code 90868. The specialty society indicated that the typical course of treatments per patient is 36, therefore the 2019e Medicare utilization of 238,754 represents approximately 6,600 patients. The Workgroup agreed that the physician time, clinical staff time and direct practice expense inputs continue to change for transcranial magnetic stimulation (TMS) and to survey now may be premature.

The Workgroup recommends that codes 90867-90869 maintain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.

III. CPT Assistant Analysis (73580)

CPT code 73580 *Radiologic examination, knee, arthrography, radiological supervision and interpretation* was originally identified in February 2008, via the high volume growth screen. The specialty societies indicated that the increase in utilization was due to a non-coverage decision for arthroscopic lavage. Physicians use these codes to report different procedures. In February 2009, these procedures were referred to CPT for possible deletion of 73580 and 27370 and the creation of a new code to accurately describe the procedure that is being performed, including the radiologic guidance in the procedure codes. In October 2009, the RUC recommended that the specialty societies develop a CPT Assistant article to address misuse reporting of arthrography codes. The CPT Assistant article was published in June 2012. In April 2015, the RAW reviewed services in which the RUC recommended that a CPT Assistant article be developed. The Workgroup requested that the specialty societies develop an action plan to address the increase in utilization and the effectiveness of the CPT Assistant article. In October 2015, the RAW recommended to review again in 2017 to determine if the 2015 CPT changes were effective. In October 2017, the RUC recommended that the RAW review this service in October 2020 via action plan and show data for the total joint replacement codes in correlation with this service.

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

IV. High Volume Growth (01916, 64615, 92526 and 92610)

01916 Anesthesia for diagnostic arteriography/venography

In October 2019, the Workgroup identified CPT code 01916 with Medicare utilization of 10,000 or more and has increased by at least 100% from 2013 through 2018e. The Workgroup requested action plans for review at the January 2020 Relativity Assessment Workgroup meeting. In January 2020, the RUC recommended to review at the October 2020 RAW meeting when one year of additional data (2019) is available. The specialty society noted that CPT code 01916 is performed with many surgical services, but primarily with the dialysis circuit intervention services (36901-36909) that were developed in 2017, which coincides with the greatest increase in utilization for CPT code 01916. While it is expected that there be an increase in utilization of anesthesia services with the introduction of this new code family, the total number of times the new codes describing dialysis circuit intervention services are billed with 01916 remains low. For

example, only 8.5% of the total times 36902 was billed, it was in conjunction with 01916 demonstrating that 01916 is only being used in a small proportion of the surgical cases. The Workgroup noted that there are many ways to report this service and it may be difficult to track. **The Workgroup recommends reviewing CPT code 01916 in 3 years (October 2023).**

64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

In October 2019, the Workgroup identified this service with Medicare utilization of 10,000 or more and has increased by at least 100% from 2013 through 2018e. In January 2020, the RUC recommended to refer code 64615 to CPT to clarify this service and make the code more granular to what is being performed. This service was originally surveyed by various specialties, some of which may no longer be typically providing this service. When preparing to develop a CCA, the specialties realized that an additional code was not necessary. The number of injections will never be less than what is stated in the rationale; ophthalmology surveyed the other codes that they use in this family, therefore the correct specialties were surveyed; and the increase in utilization was appropriate as this code was new in 2013. The specialties requested that this code be discussed again at the July 2020 Workgroup meeting.

The Workgroup reviewed code 64615 and determined that the growth in utilization is appropriate and the previous concerns regarding the last review were addressed, except that this service was valued as a 000-day service, but CMS designated this service as a 010-day global period. The Workgroup noted that the specialty societies should work with CMS to correct this anomaly as CPT code 64615 was valued without any post-operative visits. **The Workgroup recommends removing CPT code 64615 from the High Volume Growth screen.**

92526 Treatment of swallowing dysfunction and/or oral function for feeding

92610 Evaluation of oral and pharyngeal swallowing function

In October 2013, CPT codes 92526 and 92610 were identified through the High Volume Growth screen and the RUC recommended that the RAW review the utilization in 3 years. In October 2017, the RUC recommended that these services be reviewed in 3 years (2020) as possible miscoding was being investigated. The Workgroup reviewed these services and noted that the previous miscoding has been addressed by the HHS Office of Inspector General resulting in recoupment of an overpayment. The organization indicates that the current growth is appropriate. **The Workgroup recommends removing CPT codes 92526 and 92610 from the High Volume Growth screen.**

V. New Technology/New Services

In 2005, the AMA RUC began the process of flagging services that represent new technology or new services as they were presented to the Committee. At this meeting the Workgroup continued review of CPT 2017 codes that were flagged at the October 2015 and January 2016 RUC meetings, with 3 years of available Medicare claims data (2017, 2018 and preliminary 2019 data).

The Workgroup reviewed the action plans and recommends the following:

Issue	CPT Code	Recommendation
Insertion of Spinal Stability Distractive Device	22867 22868 22869 22870	Remove codes 22867 and 22868 from list, no demonstrated technology diffusion that impacts work or practice expense. The primary performers did not comment on 22869/22870. The Workgroup requests an action plan from the primary performers of code 22869 and 22870 (interventional pain management, pain management, anesthesiology and physical medicine and rehabilitation) for review at the January 2021 Relativity Assessment Workgroup meeting.

Issue	CPT Code	Recommendation
Closure Left Atrial Appendage with Endocardial Implant	33340	Review in two years (October 2022); new FDA indication recently released, suggesting this service is still changing.
Mechanochemical (MOCA) Vein Ablation	36473 36474	Review in October 2021 with the other codes in this family identified via the 2021 new technology/new services screen (36475-36479).
Esophageal Sphincter Augmentation	43284 43285	Review in 3 years (October 2023). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.
Laparoscopic Radiofrequency Ablation of Uterine Fibroids	58674	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Endoscopic Decompression of Spinal Cord Nerve	62380	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Respiratory Motion Management Simulation	77293	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Transcranial Magnetic Stimulation (TMS)	90867 90868 90869	Review in 3 years (October 2023). <i>Also reviewed via the Contractor Priced High Volume screen at this meeting.</i>
Closure of Paravalvular Leak	93590 93591 93592	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
Reflectance Confocal Microscopy	96931 96932 96933 96934 96935 96936	Review in 3 years (October 2023).
Complex Chronic Care Coordination Services / Chronic Care Management	99487 99489 99490	Survey for January 2021 with the principal care management code that is under consideration at the October 2020 CPT meeting.

VI. Reiteration of Screens

- **Site of Service Anomalies (27446)**

Outpatient Setting but Includes Hospital Visits

The Workgroup identified CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period and 2019e Medicare utilization over 10,000. The Workgroup reviewed hospital outpatient claim data to confirm that this service is typically performed in the outpatient setting without any observation or overnight stay. Of 414 carrier line items (from the 5% physician claim files) for CPT code 27446 that were matched to a hospital outpatient claim, just 44 (11 percent) appear to have involved observation care with an overnight stay.

The Workgroup noted that CPT code 27446 is a site of service anomaly and visits are currently included in this service that are not typical of what is occurring. **The Workgroup recommends that CPT code 27446 be surveyed for January 2021 with the appropriate code family.**

- **CMS/Other Source**

The Workgroup identified 11 codes with 2019 estimated Medicare utilization over 20,000. Codes G0407, G0408, G0422, G0423, G0500, G0506, G6001, G6012, G6013, G6015 and G6017. **The Workgroup requests that action plans be reviewed for these services at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or the G code should be surveyed.**

- **Harvard Valued utilization over 30,000 (92284)**

The Workgroup identified one CPT code 92284 *Dark adaptation examination with interpretation and report* with 2019e Medicare utilization over 30,000. **The Workgroup requests that the specialty societies submit an action plan addressing CPT code 92284 for January 2021.**

- **High Volume Growth – 2014-2019e**

The Workgroup identified seven codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2014 through 2019e. CPT codes 00918, 63685, 75561, 75572, 75574, 77293 and 93655. The Workgroup noted that CPT code 77293 was reviewed at this meeting via the New Technology/New Services screen and the growth was appropriate. Therefore, the Workgroup removed 77293 from this screen as well. **The Workgroup requests that the specialty societies submit an action plan for codes CPT codes 00918, 63685, 75561, 75572, 75574 and 93655 for January 2021.**

- **Work Neutrality (CPT 2019) (92273, 92274 & 0509T)**

The Workgroup 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 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. However, 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). **The Workgroup requests that the specialty societies submit an action plan for January 2021 to address this issue.**

VII. Informational Items

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

Members Present: Scott Manaker, MD, PhD, (Chair), David Han, MD (Vice Chair), Jordan Pritzker, MD (CPT Resource), Jennifer Aloff, MD, Amy Aronsky, DO, Gregory Barkley, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal Cohen, MD, Leisha Eiten, AuD, William Gee, MD, Mollie MacCormack, MD, Dheeraj Mahajan, MD, Bradley Marple, MD, Tye Ouzounian, MD, Donald Selzer, MD, Elisabeth Volpert, APRN, Thomas Weida, MD, Adam Weinstein, MD

I. 000 and 010 Day Global Pre-Service Time Workgroup

The Practice Expense (PE) Subcommittee discussed the pre-service clinical staff time (CA001-CA005) related to changes in global periods, since this issue arose in three separate tabs during the meeting. The PE Subcommittee acknowledged that there are several existing standard time packages which should be used as a starting point to develop pre-service time recommendations and questioned the use of global periods as a “surrogate” for the complexity of pre-service clinical needs.

It was noted that the existing pre-service clinical staff time standards have been reviewed multiple times, most recently in early 2020 when the PE Subcommittee formed a 000 and 010 Day Global Pre-Service Time Workgroup to compile data on 000 and 010-day pre-service clinical staff time, identify services that are major surgeries and validate that the pre-service time is appropriate. This Workgroup reported back in April 2020:

The Workgroup reviewed the current 000 and 010 day pre-service time standards. 000 and 010 day global codes are presumed to have no pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. A pre-service time allocation of 18 minutes for the non-facility and 30 minutes for facility based procedures may apply to a select number of codes if there is evidence that there is extensive use of clinical staff. In addition, 15 minutes for facility based procedures may apply to a select number of codes if there is evidence that there is minimal use of clinical staff. The Workgroup agreed that the current process whereby the presenting specialty societies provide rationale for pre-service time higher than the standard has allowed for appropriate clinical staff time. The Workgroup determined that there is no systemic flaw in the pre-service time for 000 and 010 day global services. **The PE Subcommittee reviewed the recommendation of the Workgroup and recommends no change to the current pre-service clinical staff time for individual codes with 000 and 010 day global periods.** Moreover, “The Workgroup acknowledged that there is no universal standard definition of major surgery.”

The subcommittee recommended that a workgroup be formed to continue to review the appropriate surrogate to differentiate major versus minor procedures, whether that continues to be the surgical global period or some other metric. The Chair recommended that the deliberations from the previous workgroup and earlier workgroups developing the various pre-service clinical staff time packages serve as a basis for this effort. **The PE Subcommittee agreed that it is appropriate to form a Workgroup to consider how changes in global periods from 90 day to 000 or 010 day are handled with regard to pre-service clinical staff time.**

II. Injection Packs

The PE Subcommittee discussed the use of injection packs and the need for substitutions and additional line items as was seen with Tab 17 Destruction by Neurolytic Agent. The subcommittee specifically discussed the specialties' use of SA041 *pack, basic injection* which includes 10 ml povidone solution (Betadine) and the addition of SJ081 *swab, patient prep, 1.5 ml (chloraprep)*. It was suggested that the use of Betadine is no longer typical. **The PE Subcommittee determined that staff should identify those codes that use Betadine and inquire of the appropriate specialties whether they should be revised.** This task led to a larger discussion of packs: both "virtual" packs assigned as placeholders by the subcommittee and commercially produced packs/kits. A member suggested to include a question on the PE SOR to delineate whether a pack is virtual or commercial. Further discussion emphasized the need for "guardrails" to justify when additional supply items are added and to avoid reverting to having line items for every supply. Also, there may be a need for a "pack update process." **For all these reasons, the PE Subcommittee recommended that a Workgroup be formed to consider revisions in the injection packs and in how to address individual items for the packs.**

III. Timing of Workgroup Appointments

Appointments to the two new PE Subcommittee Workgroups will be made after the January RUC meeting due to time constraints during the pandemic and to coincide with the new Subcommittee/Workgroup assignments in February 2021.

IV. Time-Outs in Pre-Service Time

The PE Subcommittee discussed whether the required use of time-outs is currently accounted for in pre-service clinical time. A member stated that time-outs are universal for invasive procedures so we have not included additional time. However, there are currently codes in the database that include time-out in the pre-service description of work. Another member questioned whether the "wait" time in Scrub/Dress/Wait accounts for time-outs in other codes. Finally, there was recognition that the time-outs are indeed additive time for yet other codes. **The PE Subcommittee determined that the issue of time-outs in pre-service time should first be discussed at the RUC meeting in the context of physician work.**

V. Practice Expense Recommendations for CPT 2022:

Tab	Title	PE Input Changes
5	Exclusion of Left Atrial Appendage	No Change
6	Harvest of Upper Extremity Artery, Endoscopic and Open	No Direct PE Inputs
7	Per-Oral Endoscopic Myotomy (POEM)	Modifications
8	Retinal Detachment Prophylaxis	No Change

Tab	Title	PE Input Changes
9	Orthoptic Training	Refer to CPT
10	Cardiac Catheterization for Congenital Defects	No Direct PE Inputs
11	3D Imaging of Cardiac Structures	Modifications
12	Prolonged Services	No PE Review
13	Anesthesia for Cardiac Electrophysiologic Procedures	No Change
14	Treatment of Foot Infection	Modifications
15	Needle Biopsy of Lymph Nodes	No Change
16	Placement/ Removal of Seton	Modifications
17	Destruction by Neurolytic Agent	Modifications
18	Strabismus Surgery	No Change
19	X-Rays at Surgery Add-On	Reaffirmed Codes/No Direct PE Inputs
20	External Cardiovascular Device Monitoring	Modifications
21	Electrophysiologic Evaluation	No Direct PE Inputs

AMA/Specialty Society RVS Update Committee
Harvest of Upper Extremity Artery
Facilitation Committee #1

Tab 6

Facilitation Members: John Proctor, MD (Chair), Margie Andraeae, MD, Dale Blasier, MD, Kathleen Cain, MD, Melissa Chen, MD, Jim Clark, MD, Jeffrey Edelstein, MD, Marc Raphaelson, MD, Michael Sutherland, MD, Thomas Weida, MD

35600 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open

The Facilitation Committee and the presenters discussed code **35600**, which is the service that did not pass during the original RUC presentation at a recommended value of 4.94. The Facilitation Committee agreed that a direct work RVU crosswalk to CPT code *37222 Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)* (work RVU= 3.73, intra-service time of 40 minutes, total time of 42 minutes), noting that both codes involve similar intra-service times and identical total times and an identical amount of physician work.

The specialty explained that the rationale for assigning this service an XXX global instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI. It was noted that it is often an NP or PA that performs the harvest procedure. The Facilitation Committee noted that NPs and PAs were not included in the survey sample and therefore it would be appropriate to resurvey this service for the next meeting to include the providers that are potentially the dominant providers. **The Committee recommends an interim work RVU of 3.73 for CPT code 35600.**

35XX0 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic

The Facilitation Committee reviewed the survey 25th percentile of 5.63 (IWP/PUT of 0.125) and concurred that the survey respondents overestimated the work involved in performing this service. The Facilitation Committee agreed that a direct work RVU crosswalk to CPT code *33987 Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)* (work RVU= 4.04, intra-service and total time of 45 minutes), noting that both codes involve an identical amount of time and amount of physician work to perform. The specialty explained that the rationale for assigning this service an XXX global instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI. It was noted that it is often an NP or PA that performs the harvest procedure. The Facilitation Committee noted that NPs and PAs were not included in the survey sample and therefore it would be appropriate to resurvey this service for the next meeting to include the providers that are potentially the dominant providers. **The Committee recommends an interim work RVU of 4.04 for CPT code 35XX0.**

New Technology List

The Facilitation Committee recommends that new CPT code 35XX0 be added to the New Technology List.

The Facilitation Committee recommends the following work values and physician times to be interim and for the specialty society to resurvey these services for the January 2021 RUC Meeting:

Code	Long Descriptor	wRVU	Total	Pre	Intra	Post	IWPUT
35600	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open	3.73	42		42		0.089
35XX0	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic	4.04	45		45		0.090

The Facilitation Committee briefly discussed the direct practice expense inputs and noted that they were appropriate as recommended by the Practice Expense Subcommittee.

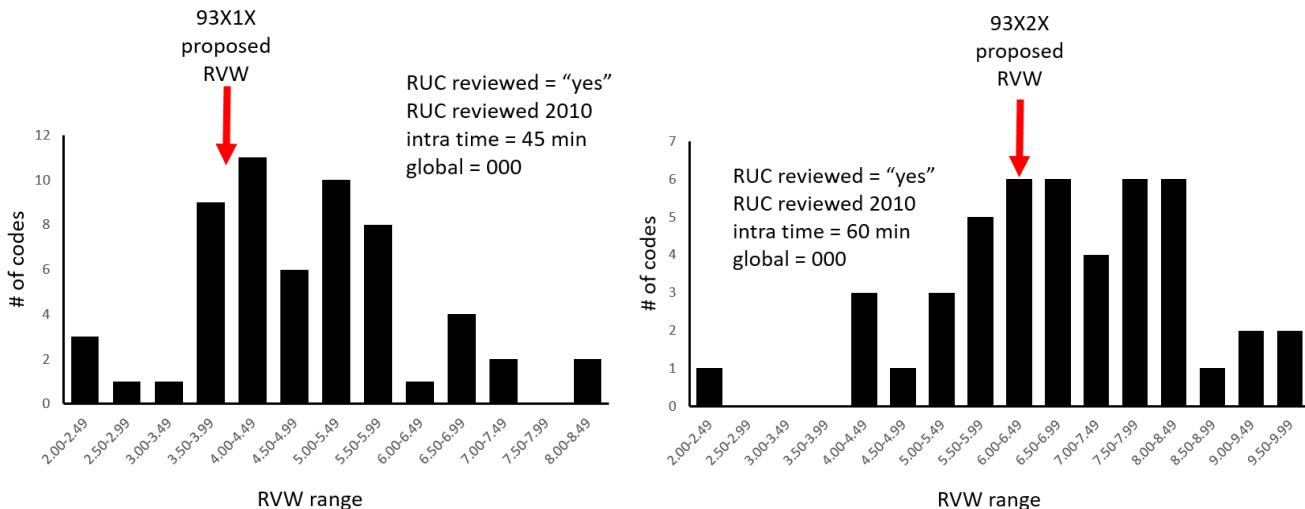
Facilitation Members: G. Edward Vates, MD (Chair), Michael Bishop, MD, Gregory DeMeo, MD, Matthew Grierson, MD, Timothy Laing, MD, Alan Lazaroff, MD, M. Douglas Leahy, MD, Brad Marple, MD, Dee Adams Nikjeh, PhD, CCP-SLP, Matthew Sideman, MD, Ezequiel Silva, III, MD

The Facilitation Committee reviewed the family of 6 new CPT codes describing cardiac catheterization for congenital heart defects (five 000-day global codes and one ZZZ add-on code). At the beginning of the discussion, the specialty presenters noted that the vast majority of diagnostic catheter studies were performed in children who were healthier with simpler cardiac defects when the previous code structure was last valued in 1997; children with more significant cardiac defects had no treatment options, so catheterization was not warranted. Over the past 23 years, as result of improvements in both technique and technology, the specialty has evolved and now performs a substantially larger number of more complex diagnostic evaluations to guide more complex interventional procedures, and the typical patient is now a more complex patient with more pathology (making the argument for compelling evidence). In a related vein, the times captured in surveys in 1997 are unlikely to have been accurate because of the small number of specialists surveyed who had adequate experience (a reflection of the nascent nature of the specialty 23 years ago), and the Facilitation Committee agrees with the specialty presenters that the times recorded in the RUC database from 1997 should be considered with significant suspicion when looking at the current surveys and coming to a decision about work values.

The Facilitation Committee and the presenters discussed code **93X1X**, which is the service that did not pass during the original RUC presentation, as well as **93X2X**. As part of this discussion, the Committee and presenters covered deleted code 93530, which was previously the only right heart only catheterization code designed to capture all possible pathologies for patients with congenital heart disease. This work is now being segmented into 93X1X for patients with simple defects, defined in CPT as having normal native connections, and 93X2X for the more complex patients with abnormal native connections. The Facilitation committee concurred that this change in code structure is one of several reasons why comparing the 1997 physician times for 93530 to both 93X1X and 93X2X is precarious at best.

The Facilitation Committee also noted that when the deleted code was last evaluated by the RUC and CMS in 1997, both the RUC and CMS evaluated physician time with much less rigor and the valuation process has greatly evolved and become more refined. Correspondingly, deleted code 93530 has an inappropriately low IWP/PUT of 0.0206, which implies that the 1997 times are overstated relative to the current work RVU. Separately, the Facilitation Committee also noted that 0.25 work RVUs and 10 minutes of pre-service time were systematically removed from the deleted code in 2017 when moderate sedation was unbundled from all services following the deletion of CPT appendix G. As 93530 is typically performed on an infant under general anesthesia, the specialty noted and the Facilitation Committee agreed that including 93530 in the moderate sedation unbundling initiative was inappropriate, and had an unwarranted downward effect on the wRVUs currently credited to the code. The original wRVU for 93530 approved by the RUC was 4.25.

The Facilitation Committee also reviewed a search of the RUC database using the following criteria: RUC reviewed = “yes”, RUC reviewed since 2010, global = 000, intra-service time = 45 minutes. Looking at the 59 codes captured in this search, it became clear that the proposed RVW for 93X1X was at the lower end of the bell curve for the codes revealed by the search. Similarly, for 93X2X the proposed RVW was in the middle of the curve for codes revealed by a similar search (intra-service time = 60 minutes). This helped to place the proposed RVW within the context of “values out there” that have been RUC approved and combined with the discussion about the faulty nature of times from the 1997 survey, brought the Facilitation Committee to a place where we could better understand the times and values proposed by the specialty presenters.



The additional discussion with the specialty regarding the flawed current physician times for deleted code 93530, as well as changes in technology and the patient population that now undergoes the procedure, helped the Facilitation Committee understand and support the original recommended values and times for the first four codes in the family (**93X1X-93X4X**) as detailed in the below table, and the Committee is now recommending those times and values. As mentioned, these codes seem to fit well with in the spectrum of codes already approved by the RUC (see bar graphs above) and also represent a graded escalation in values that fit with the complexity/intensity of work within the family. The Committee supported these recommendations by comparing these four codes each to a separate reference code with either an identical or very similar intra-service time:

- 93X1X to reference code 49422 *Removal of tunneled intraperitoneal catheter* (work RVU= 4.00, intra-service time= 45 min)
- 93X2X to reference code 36217 *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family* (work RVU= 6.29, intra-service time= 60 minutes)
- 93X3X to reference code 93453 *Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU=5.99, intra-service time= 45 min)
- 93X4X to reference code 93461 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization...* (work RVU=7.85, intra-service time= 60).

For code **93X5X**, the Facilitation Committee disagreed with the originally proposed value by the specialty, though did still concur that the survey respondents underestimated the amount of physician work involved in this new CPT code. The Facilitation Committee recommends retaining the current work value of 9.99 from deleted code 93532 for 93X5X. To justify a value of 9.99, the Committee compared the survey code to reference code 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch* (work RVU= 9.85, intra-service time= 68, total time=127) and noted that, although the survey code involves more intra-service and total time, that is offset by it being somewhat less intense to perform. The Committee agreed both services should be valued similarly.

For add-on code **93X6X**, the Facilitation Committee recommends a direct work RVU crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service time= 20 min). The Committee noted

that both services involve an identical amount of physician work and time and therefore, should be valued the same.

The Facilitation Committee recommends the following work values and physician times:

Code	Long Descriptor	wRVU	Total	Pre Eval	Pre Posit	Pre SDW	Intra	Imm Post	IWPUT
93X1X	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	3.99	148	40	3	15	45	45	0.0422
93X2X	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	6.10	172	46	3	15	60	48	0.0634
93X3X	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	6.00	158	46	3	15	48	46	0.0781
93X4X	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	7.91	181	50	3	15	60	53	0.0902
93X5X	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections	9.99	216	55	3	15	83	60	0.0871
+93X6X	Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)	1.75	20				20		0.0875

The Facilitation Committee noted that these facility-only service do not include any direct practice expense inputs.

**AMA/Specialty Society RVS Update Committee
Treatment of Foot Infection
Facilitation Committee #3**

Tab 14

Facilitation Members: G. Edward Vates, MD (Chair), Michael Bishop, MD, Gregory DeMeo, MD, Matthew Grierson, MD, Alan Lazaroff, MD, Lance Manning, MD, Eileen Moynihan, MD, Donna Sweet, MD, Matthew Sideman, MD and Ezequiel Silva, III, MD.

28001 Incision and drainage, bursa, foot

The facilitation committee reviewed the survey results for CPT code 28001 and determined that the survey median work RVU of 2.00 for podiatrists appropriately accounts for the work required to perform this service. The committee noted that this service is primarily performed by podiatrists (99%) in the non-facility setting (2019 Medicare data), supporting the use of the median response rate of podiatrists to assign a value. The committee also noted and discussed the bimodal distribution of the data; the responses from the orthopaedic surgeons suggest a different patient population and possibly different physician work that the specialty societies could consider in future coding recommendations. The committee noted supporting reference services that have the same intra-service time and similar total time: CPT code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU = 2.00 and 20 minutes intra-service time) and 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU = 2.00). **The facilitation committee recommends a work RVU of 2.00 for CPT code 28001.**

28002 Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space

The facilitation committee reviewed the survey results for CPT code 28002 and determined that the survey median of 3.73 work RVUs overestimated the work required to perform this service. The committee recommends a crosswalk to CPT code 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy*; (work RVU = 3.50) as it has the same intra-service time of 30 minutes and similar total time of 86 minutes. The committee noted that 28002 is typically performed in the facility setting and therefore there was not a bimodal survey distribution to consider; additionally, the increment in time and physician work seemed to be appropriately captured with the crosswalk value. **The facilitation committee recommends a work RVU of 3.50 for CPT code 28002.**

28003 Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

The facilitation committee reviewed the survey results for CPT code 28003 and determined that the survey median of 5.28 work RVUs appropriately accounts for the work required to perform this service. The committee noted that there was again a bimodal distribution in the survey responses comparing podiatrists to orthopaedic surgeons; while this might represent different patient populations and different physician work for the two specialties, the societies' expert panel settled on the combined median wRVU recommendation. The specialty societies indicated, and the committee agreed that CPT code 28003 is appropriately more work than 28001 and 28002 because it is a more complex procedure involving more complex tissue exploration and a larger area. This recommendation is supported by similar service, 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) that has the same intra-service time of 45 minutes. **The facilitation committee recommends a work RVU of 5.28 for CPT 28003.**

CPT Code	Recommended work RVU	Pre Evaluation	Pre Positioning	Pre S/D/W	Intra-Service	Immediate Post
28001	2.00 (podiatry median)	17	3	5	20	15
28002	3.50 (crosswalk)	30	5	15	30	20
28003	5.28 (survey median)	40	10	15	45	20

