

**AMA/Specialty Society RVS Update Committee
October 6-9, 2021**

Meeting Minutes

I. Welcome and Call to Order

The RUC met virtually in October 2021 due to the COVID-19 pandemic. Doctor Ezequiel Silva, III called the virtual meeting to order on Thursday, October 7, 2021, at 9:00 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:

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

RUC Alternates:

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

II. Chair's Report

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

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

- Doctor Silva communicated the following guidelines related to confidentiality:
 - All RUC attendees must adhere to the confidentiality agreement that was signed prior to the meeting.
 - Recording devices are prohibited.
 - The full confidentiality agreement can be found on the RUC Collaboration site (Structure and Functions).
- Doctor Silva reviewed the financial disclosures:
 - RUC members completed a statement of compliance with the RUC Financial Disclosure Policy.
 - There were no stated disclosures/conflicts for this meeting.
- Doctor Silva conveyed the following RUC member information:
 - The RUC assumes that RUC members are “seated.” Once seated for a tab, the RUC member must stay in the seat for the entire issue until completion with vote.
 - If an Alternate replaces a RUC member during the virtual meeting, they must announce as the RUC transitions to a new issue. The Alternate may do this by using the “raise hand” option.
 - RUC staff recommends using the view “side-by-side” under view options at the top in order to view shared documents with “speaker” view.
- Doctor Silva gleefully acknowledged the 30th Anniversary of the RUC and thanked the RUC members for many years of collaborative service.
- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff:
 - Perry Alexion, MD – Medical Officer
 - Arkaprava Deb, MD – Medical Officer
 - Edith Hambrick, MD – Medical Officer
 - Scott Lawrence – Acting Deputy Director, Division of Outpatient Care
 - Karen Nakano, MD – Medical Officer
 - Gift Tee, MPH – Director, Division of Practitioner Services
 - Pamela Foxcroft Villanyi, MD – Medical Officer
- He also noted that several CMS observers were present for the virtual meeting.
 - Julie Adams
 - Anne Blackfield
 - Larry Chan
 - NailahGallego, MD
 - Liane Grayson, PhD, MPH
 - Kathleen Kersell
 - Morgan Kitzmiller
 - Ann Marshall
 - Geri Mondowney
 - Patrick Sartini
 - Terry Simananda
 - Michael Soracoe, PhD
 - Pam West

- Doctor Silva welcomed the following Contractor Medical Directors:
 - Janet Lawrence, MD
 - Richard W. Whitten, MD, MBA
- Doctor Silva welcomed the following Member of the CPT Editorial Panel:
 - Jordan Pritzker, MD, MBA – CPT RUC Member
 - Lawrence Simon, MD – CPT Panel Member
- Doctor Silva announced new RUC Members:
 - Amy Aronsky, DO (AOA)
- Doctor Silva announced new RUC Alternate Members:
 - Kristopher Kimmel, MD (AANS)
- Doctor Silva conveyed the Lobbying Policy:
 - “Lobbying” means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
 - Any communication that can reasonably be interpreted as inducement, coercion, intimidation, or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
 - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
 - Full lobbying policy found on Collaboration site (Structure and Functions).
- Doctor Silva announced the updated RUC reviewer guidelines:
 - To enable more efficient RUC reviews, AMA staff shall review specialty Summary of Recommendation forms (SORs) for adherence to our general guidelines and expectations, such as:
 - Specialty representation
 - Survey methodology
 - Vignette
 - Sample size
 - Budget Neutrality / Compelling evidence
 - Professional Liability Insurance (PLI)
- Doctor Silva shared the following procedural issues for RUC members:
 - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue, and it will be reflected in the minutes.
 - RUC members or alternates sitting at the table may not present or debate for their society.
 - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
 - E/M services that are widely performed by most specialties do not require RUC members to recuse themselves from discussion at this meeting. This applies to:
 - Tab 10 Inpatient and Observation Care Services
 - Tab 11 Consultations
 - Tab 14 Prolonged Services –Without Direct Patient Contact
 - Tab 15 Prolonged Services – on the Date of an E/M

- Doctor Silva conveyed the following procedural guidelines related to Voting:
 - Work RVU = 2/3 vote
 - Motions = Majority vote
 - RUC members will vote on all tabs using the single voting link provided via email.
 - You will need to have access to a computer or smart phone to submit your vote.
 - If you are unable to vote during the meeting due to technical difficulties, please contact Michael Morrow.
 - RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
 - We vote on every work RVU, including facilitation reports.
 - If members are going to abstain from voting, please notify AMA staff so we may account for all 29 votes.
- Doctor Silva stated the following procedural guidelines related to RUC Ballots:
 - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.
 - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
 - You must enter the work RVU, physician times and reference codes to support your recommendation.
 - Facilitation Committee meetings are set up for 4pm-6pm via Microsoft Teams if necessary.
- Doctor Silva explained the following RUC established thresholds for the number of survey responses required:
 - Codes with ≥ 1 million Medicare claims = 75 respondents
 - Codes with Medicare claims between 100,000-999,999 = 50 respondents
 - Codes with $< 100,000$ Medicare claims = 30 respondents
 - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Silva shared a new process for reviewing Research Subcommittee recommendations:
 - The Research Subcommittee meeting reports are always included in the Research Subcommittee folder.
 - For ease, now you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.
- Doctor Silva conveyed information related to Tab 7 Prolonged Psychotherapy:
 - Last week, the CPT Editorial Panel rescinded new code **908X0**
 - This issue has been removed from our agenda
- Doctor Silva introduced two new AMA staff members:
 - Katlyn Palmer, MPH
 - David Harms, MPA

III. Director's Report

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

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Approved by the RUC January 13, 2022

- Ms. Smith conveyed the following information regarding the RUC Database application:
 - The RUC database has been updated and is available at <https://rucapp.ama-assn.org>
 - Orientation is available on YouTube at <https://youtu.be/3phyBHWxIms>
 - Accessible both online and offline from any device, including smartphones and tablets
 - Download offline version, you will be prompted whenever there is an update available.
 - Be sure to clear cache and log off before downloading a new version.
 - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
 - Changes for the 2021 RUC database application include:
 - 2019 billed together and units of service data - provides and overview of how often codes are billed with other services.
- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process:
 - The RUC Process webinars may be accessed via the RUC Collaboration home page or click “General Resources” from the left navigation bar and then “New to the RUC” and “RUC Process Webinars & Presentations.”
 - The RUC Process webinars may also be accessed directly via the YouTube link: <https://www.youtube.com/playlist?list=PLpUAhDfIHfcoS89T0wxivYpHmsYl8fxZp>
- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2023 and 2024 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Dec 14, 2021	Jan 12-15, 2022	San Diego, CA	CPT 2023
Apr 5, 2022	Apr 27-30, 2022	Chicago, IL	CPT 2024
Aug 23, 2022	Sept 21-24, 2022	Chicago, IL	CPT 2024

IV. Approval of Minutes from April 2021 RUC Meeting

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

V. CPT Editorial Panel Update (Informational)

Jordan Pritzker, MD, MBA provided the following CPT Editorial Panel update from the September 30-October 1, 2021, Panel meeting and the continuing response to the COVID-19 pandemic:

- Panel meeting activity in response to COVID-19 pandemic:
 - The Panel has continued to be busy creating COVID vaccine codes
 - 24 total CPT codes created for COVID-19 Vaccine product and administration codes
 - 7 vaccine product codes (Pfizer, Moderna, Janssen, AstraZeneca & Novavax)
 - 17 vaccine administration codes (per dose)
 - Note:
 - Approved at the October meeting -3 new codes for the Pfizer pediatric vaccine (5-11 y/o)
 - Next on the VCC review schedule (near future)
 - J&J booster code
 - Moderna pediatric codes

- The Panel thanks the RUC for their work on immediately reviewing the physician work and practice expense for these new codes
- September 2021 CPT Editorial Panel meeting recap:
 - 77 agenda items
 - Notable items:
 - 6 Digital medicine-related CCAs
 - 28 Category III code applications
 - EM Guideline Revisions -Test Ordering with MDM (Tab 8): Request to allow the decision to order a test as an element within medical decision making (MDM) for E/M level assignment. This represents an area of significant previous discussion by the CPT/RUC E/M Workgroup.
 - Endovascular Revascularization-Lower Extremity (Tab 19): Request to delete lower extremity endovascular revascularization codes 37220-37235 and establish 32 new codes (37XX1, 37X02-37X32) to reflect current practice in performing these procedures.
 - Taxonomy of Artificial Intelligence (AI) for Medical Services and Procedures (Tab 50): Add an Appendix that will improve the terminology and understanding of AI as it relates to the CPT code set.
 - Appendix P Revisions (Tab 81): Add the star symbol “star” to codes 92507, 92521, 92522, 92523, 92524, 92526, 92601, 92602, 92603, 92604, 96105, 96125 to be used for Synchronous Telemedicine Services.
 - Audio Only Telehealth Modifier (Tab 82): Add a Modifier to append to codes when a service is provided via an audio-only technology (primarily via telephone).
 - RUC Referral –Tab 21 -64490-64495 Guideline Revisions
- CPT Editorial Panel Ad Hoc Workgroups developed based on the activities of the panel meeting:
 - Neoplastic Targeted GSP Workgroup
 - Workgroup Charge: The workgroup will review the issues raised in the withdrawn Tab 32 from the May 2020 meeting, "GSP Targeted Panel-Solid Tumor", specifically the feasibility of removing separating DNA and RNA analysis in the procedures captured in codes 81445, 81450, and 81455. And if feasible determine the most appropriate coding solution for these services under the proposed new construct.
 - Unlisted Code Workgroup
 - Workgroup Charge: The Workgroup will investigate the use of unlisted codes, specifically how they are used in conjunction with existing Category I and III CPT codes during the same intervention (eg, procedure, analysis), and determine the need for CPT to provide unifying guidance on their appropriate use. If such guidance is recommended, then the Workgroup will provide a draft of such guidance to the Editorial Panel.
- February 2022 CPT Editorial Panel meeting:
 - The next Panel meeting is February 3-5, 2022 (Thursday-Saturday)
 - The next application submission deadline is November 3, 2021 (for February 2022 meeting)
- Doctor Pritzker answered questions from the attendees:
 - A RUC member inquired about the current granularity of COVID-19 vaccine and immunization CPT codes and Doctor Pritzker noted that the CDC specifically requested granularity in the CPT coding.

- A RUC member requested updates on the CPT conversation regarding AI. Doctor Silva stated that it might be appropriate to have a presentation by those that lead the effort.
- Doctor Pritzker took a moment to clarify the definitions of third dose versus booster dose of the COVID vaccines. The third dose is intended for when the initial two doses were insufficient for immunocompromised individuals and the booster dose is for when the primary series is sufficient, and immunity may have waned over time.

VI. Washington Update (Informational)

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

- CY 2022 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Proposed Rule:
 - Four key proposals:
 - Telehealth and Other Services Involving Communications Technology
 - Clinical Labor Pricing Update
 - Evaluation and Management (E/M) Visits
 - Medicare Quality Payment Program (QPP)
 - The AMA submitted detailed comments in response to the proposed rule.
 - The final rule is expected later this year; effective date of January 1, 2022
- CY 2022 Proposed Rule:
 - Telehealth and Other Services Involving Communications Technology
 - AMA strongly supports CMS proposals to extend coverage of services added to telehealth list in response to the PHE through end of 2023
 - Recommends telephone E/M codes 99441-99443 be added to this category
 - AMA supports proposal to expand definition of “telecommunications system” for the purpose of telehealth to include audio-only
 - Only applies to mental health and substance abuse telehealth services
 - AMA continues to recommend that the definition of “direct supervision” include immediate availability through the virtual presence of the supervising physician using real-time, interactive audio/video communications technology be made permanent
 - Clinical Labor Pricing Update
 - AMA supports CMS proposal to use the Bureau of Labor Statistics (BLS) wage data
 - Evaluation and Management (E/M) Visits
 - AMA urges CMS not to require a modifier to be reported for split (or shared) visits
 - CMS should work with the CPT/RUC Workgroup on E/M to create a proposal to the CPT Editorial Panel to clarify the reporting in CPT Guidelines
 - Payment for Infection Control/Safety Protocols
 - AMA urges CMS to issue IFR to immediately implement and pay separately for CPT 99072 with no patient cost sharing through duration of PHE
 - Global Surgical Codes
 - AMA continues to oppose decision not to incorporate revised office visit and outpatient E/M values in global surgical codes; Urges CMS to apply office visit increase to the office visits included in the global surgical payment

- Remote Therapeutic Monitoring
 - AMA urges CMS to clarify that the RTM codes are in fact general medicine codes
- Medicare Quality Payment Program (QPP):
 - 2022 QPP Changes
 - AMA urges CMS to continue COVID-19 flexibilities in 2022 and work with specialty societies to ensure successful implementation of new MIPS Value Pathways approach
 - AMA recommends that CMS work with the stakeholders to improve payment model design and implementation so that more physicians have opportunities to voluntarily participate in APMs that support the delivery of high-quality care to their patients
 - MIPS 2021 Relief
 - Submit a hardship exception application for exemption from one or more categories due to COVID-19 by December 31, 2021.
- Surprise Billing:
 - No Surprises Act (NSA) –prohibits surprise billing; creates arbitration process for determining payment for out-of-network providers
 - Passed Congress late 2020 –most provisions take effect January 1, 2022
 - First IFR issued July 1, 2021
 - Prevents surprise medical bills for emergency services
 - Outlines process for determining Qualifying Payment Amount (QPA)
 - Establishes structure for interaction of state and federal surprise billing requirements
 - Process for patient notice and consent
 - Establishes criteria for facilities/physicians to provide required patient notices
 - Broadens complaint process for patients, physicians, plans
 - Second IFR on Independent Dispute Resolution (IDR) process released on September 30, 2021
 - AMA convened workgroup of Federation members to identify top NSA advocacy priorities and positions on key issues
 - AMA submitted additional comments to CMS in advance of IFR (QPA Comments; IDR comments)
 - AMA submitted detailed comments (prior to IFR and in response to IFR)
 - Concerns regarding how QPA (median contracted rate) will be determined
 - Concerns regarding additional potential burdens on physicians
 - Called for additional clarity regarding state/federal conflicts of law
 - Called for additional clarity and flexibility around notice and consent
- Congressional Affairs:
 - Medicare cuts looming on January 1, 2022 –9.75% total
 - Sequester –2%
 - Statutory PAYGO –4%
 - E/M budget neutrality 3.75% (across the board)
 - In the future, some physicians could also face up to 9% MIPS cuts
 - Fixes up against many competing priorities; physicians facing some pushback from Congress; some money to avert cuts is being spent
 - Likely no action before end of year; possibly in omnibus spending bill

- Omnibus spending package may be a vehicle for sequester cut fix
- Reconciliation
 - \$3.5 trillion legislative package; touches nearly every industry
 - Expansion of Medicare to include dental, hearing, vision
 - If added to PFS, 700+ dental codes to value, could result in BN cuts to PFS, will take significant amount of time
 - 2-year expansion of ACA premium subsidies
- Telehealth
 - Top AMA priority: looking to make PHE flexibilities permanent –current waivers expire at the end of the PHE
 - AMA supports CONNECT for Health Act, Medicare modernization, or clean statutory waiver at end of the PHE
- Mr. Hull answered questions from the attendees:
 - A RUC member asked for clarification regarding the extension of audio only after the PHE expires. Mr. Hull confirmed that the AMA supports payment for audio only services after the PHE expires.
 - A RUC member inquired if action would be taken before the end of the year on the Medicare cuts. Mr. Hull responded that the AMA is hopeful that it will be in a package by the end of the year and that the team is hard at work right now.
 - A RUC member requested AMA advocacy for simplification of the beneficiaries need to provide consent for each service and clarification on co-payments particularly with the principal care codes. Mr. Hull responded that they would bring this request back to the team.

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

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

Mr. Tee thanked Doctor Silva, RUC members, and RUC staff and congratulated the RUC on 30 years of great work. He also took a moment to acknowledge the new permanent Deputy Director of the Division, Doctor Scott Lawrence.

- Overview of the Proposed Rule for CY 2022:
 - On July 13, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announced and solicited public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, on or after January 1, 2022. The calendar year (CY) 2022 PFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation.
 - The 60-day comment period closed on September 13, 2021, and CMS is actively working on reviewing the comments received. We thank the AMA and other stakeholders for their comments.
- Highlights from the CY 2022 Proposed Rule:
 - CY 2022 PFS Rate-Setting/Conversion Factor
 - Evaluation and Management Services

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- Implementation of Additional CAA Requirements
- Telehealth and Other Services Involving Communications Technology
- Therapy Services
- Vaccine Administration
- CY 2022 PFS Rulemaking updates and leadership updates:
 - CMS is actively working on CY 2022 PFS rulemaking
 - Expected to come out November 1, 2021
 - HHS and CMS leadership
 - Department of Health and Human Services:
 - Secretary: Xavier Becerra
 - Deputy Secretary: Andrea Palm
 - Centers for Medicare and Medicaid Services:
 - Administrator: Chiquita Brooks-LaSure
 - Principle Deputy Administrator and Chief Operating Officer: Jonathan Blum
 - Deputy Administrator and Director of the Center for Medicare: Dr. Meena Seshamani
 - Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation: Elizabeth Fowler
- Mr. Tee addressed questions from the attendees:
 - A RUC member asked about the review of data retrieval for Social Determinants of Health and inquired if CMS has thought about how community practices could help moving forward and use their resources to identify the individual needs of communities and collect data that is representative of all communities. Mr. Tee responded that health equity has been and continues to be an essential consideration for CMS as it develops and implements various policies.

VIII. Contractor Medical Director Update (Informational)

Janet I. Lawrence, MD, MS, FACP, Medicare Contractor Medical Director (CMD), provided the CMD update covering the collaborative Local Coverage Determination (LCDs), amniotic products, and Artificial Intelligence (AI).

- Recent Collaborative LCDs:
 - Platelet Rich Plasma (PRP) LCD
 - MolDx LCDs
 - Facet Joint Interventions for Pain Management
 - Epidural Chronic Pain Management
 - Colon Capsule Endoscopy
- Amniotic Products 101:
 - Human Cells, Tissues, and Cellular and Tissue-based Products (HCT/P's) are regulated under section 361 of the Public Health Service Act and/or the Federal Food, Drug, & Cosmetic Act.
 - To be considered HCT/P's (and regulated under the 361 pathway) the product must meet 4 criteria. The products must be:
 1. Minimally manipulated
 2. Intended for homologous use

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- 3. Not combined with another article
 - 4. Without a systemic effect
- If the 4 criteria cannot be met, then the product is regulated under section 351 as a drug, device, or biological product and requires clinical trials to demonstrate safety and efficacy.
- **Injectable Amniotic Products:**
 - These products are used in many settings for a wide range of diagnoses.
 - The FDA has clarified that all reconstituted and/or injectable amniotic and placental derived products for any use are regulated under section 351 of the Public Health Service Act (PHS Act) and/or the Federal, Food, Drug, and Cosmetic Act.
 - Product registration under the FDA website for HCT/P's (Human Cells, Tissues, and Cellular and tissue-Based Products) is not considered evidence of FDA approval under section 351. Proof of FDA approval must be for the indication being treated.
- **Artificial Intelligence (AI):**
 - There is an AI WG that has representation from the MACs, CMS, and the AMA
 - Does it matter whether AI or Algorithm? Probably Not! (At least for our purposes)
 - Main questions for this technology are:
 - 1. Is it clinically useful?
 - 2. Is it accurate?
 - 3. Does it fall within a Medicare benefit category?
 - Most of the AI marketed in the US is associated with radiological imaging.
 - There are also a number of products associated with cardiac rhythm evaluation or function.
 - The rest are associated with a variety of diagnoses including dementia and other neurological conditions, oncologic conditions, and anesthesiology.
- **AI regulation in healthcare:**
 - The most important fact at this point is that none of the AI have premarket clearance from the FDA (there is no FDA clearance process for this technology)
 - HHS' regulatory responsibility spans all aspects of healthcare including standards for healthcare delivery, payments, medical device software, medical products and food, and privacy to ensure compliance, safety, and effectiveness.
 - The Department of Health and Human Services (HHS) will continue to develop standards that inform policy and guidance for safe and transparent AI use and encourage agile and adaptable innovation.
- **Additional information:**
 - Adding workgroups as we identify the opportunity/need to collaborate
 - Finding new opportunities to engage the "old" CAC members in 21st Century Cures
 - Engaging non physician providers more
- **Doctor Lawrence addressed questions from attendees:**
 - A RUC member requested an update on the status of the PRP procedure as a Category III code and coverage by Medicare. Doctor Lawrence responded that there is a collaborative LCD coming out, at least, for the Noridian region, and is a non-coverage LCD, but as always, they are open for consideration based on the available data.

IX. Relative Value Recommendations for CPT 2023

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Approved by the RUC January 13, 2022

Endovascular Pulmonary Arterial Revascularization (Tab 4)

Mark Hoyer, MD (SCAI), Afnan Tariq, MD (SCAI), Edward Toggart, MD, Edward Touhy, MD (ACC), Thad Waites, MD (ACC) and Richard Wright, MD (ACC)

In February 2021, the CPT Editorial Panel approved a new family of Category I CPT codes to describe percutaneous endovascular repair of pulmonary artery stenosis (PAS) by stent replacement, a developing approach that has improved outcomes for some patients, particularly small children. Since other peripheral vascular angioplasty and stenting interventions were formerly the only possible method of procedure for treating PAS, endovascular pulmonary repair is not uniquely delineated in CPT due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work. CPT codes 338X3-338X7 were surveyed together for the October 2021 RUC meeting.

Over the last 20 years, advancements in stent technology have provided physicians with the opportunity to perform endovascular repair of pulmonary artery stenosis by stent placement on a broader patient population, specifically now to small children. Stents are smaller and conducive to a wider range of medical procedures, and physicians are no longer limited to only using balloon angioplasty for treating PAS in children. Therefore, the specialty societies noted, and the RUC agreed, that for procedures involving pulmonary artery stenosis on pediatric patients, the application of endovascular repair using a stent was an obstacle and a technological impossibility until more recently.

338X3 Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 14.00 for CPT code 338X3 which falls appropriately between the top two key reference services (KRS). The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time and 45 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the electronic health record (EHR) and complete data submission to the appropriate national registry, as available/appropriate.

To justify the value of 14.00, the RUC compared the surveyed code to key reference codes 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch* (work RVU= 10.96, 76 minutes of intra-service time, and 135 minutes of total time) and 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes of intra-service time and 210 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and intensity required to perform these services and therefore maintains relativity. The RUC explained that CPT code 338X3 is a unilateral procedure where the patient has normal native connections; the intensity required to perform this service is consistent with the supporting references codes and comparable to the median survey results.

For additional support, the RUC referenced the Multi-Specialty Points of Comparison (MPC) code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU= 13.75, 90 minutes of intra-service time and 166 minutes of total time) and CPT code 33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation* (work RVU= 14.00, 90 minutes intra-service time, and 183 minutes of total time) and noted that the surveyed code exactly matches the intra-service time established for these two supplementary codes. The intensity to perform the service for the MPC, comparison code, and surveyed code appropriately align in terms of their work RVU, therefore maintaining relativity in the Medicare Physician Payment Schedule. **The RUC recommends a work RVU of 14.00 for CPT code 338X3.**

338X4 Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 18.00 for CPT code 338X4. The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait, 120 minutes of intra-service time and 45 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the EHR and complete data submission to the appropriate national registry, as available/appropriate. A primary distinction between 338X4 and 338X3 is the 30-minute increase in intra-service time, which is attributed to the procedure becoming more medically complex when advancing from unilateral to bilateral in nature.

To justify the value of 18.00, the RUC compared the surveyed code to key reference code CPT codes 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes of intra-service time, and 210 minutes of total time) and determined that the surveyed code is appropriately supported by this reference service based on the similar physician work and time required to perform these services. Being that this a bilateral procedure for a patient with normal native connections, the 120-minute intra-service time allocation for 338X4, along with the measured intensity required to perform this service, are consistent with the supporting reference codes and comparable to the median from the survey results.

For additional support, the RUC referenced CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.97, 120 minutes intra-service time, and 208 minutes of total time). The RUC selected this reference code based on the similarities of physician work required to perform the service compared to the surveyed code. While the codes have identical intra-service time, the total time for the surveyed code is slightly higher, suggesting that they should be valued similarly, although the surveyed code should maintain a slightly higher work RVU. **The RUC recommends a work RVU of 18.00 for CPT code 338X4.**

338X5 Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral

The RUC reviewed the survey results from 34 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 17.33 for CPT code 338X5. The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait, 90 minutes of intra-service time and 48 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the EHR and complete data submission to the appropriate national registry, as available/appropriate.

To justify the value of 17.33, the RUC compared the surveyed code to CPT codes 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, 135 minutes of intra-service time, and 223 minutes of total time) and 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 14.75, 135 minutes of intra-service time, and 203 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and time required to perform these services. The RUC discerned that 338X3 and 338X5 are both unilateral procedures and require 90 minutes of intra-service time; however, there is larger amount of physician work required due to increased intensity and greater medical complexity of these services when patients have abnormal connections versus normal native connections.

For additional support, the RUC also referenced CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes intra-service time, and 210 minutes of total time) which has similar total time to the surveyed code but a lower intensity. The RUC recognizes similarities between these services, although the surveyed code still requires more physician work to perform the service as the RUC discerned above. Additionally, it was determined that the surveyed code was valued appropriately within the family to maintain relativity based on the description of work related to abnormal connections. **For this reason, the RUC recommends a work RVU of 17.33 for CPT code 338X5.**

338X6 Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 20.00 for CPT code 338X6. The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait, 120 minutes of intra-service time and 50 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the EHR and complete data submission to the appropriate national registry, as available/appropriate. A primary distinction between 338X6 and 338X5 is the 30-minute increase in intra-service time, which is attributed to the procedure becoming more medically complex when advancing from unilateral to bilateral in nature.

To justify the value of 20.00, the RUC compared the surveyed code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, 180 minutes of intra-service time, and 270 minutes of total time) and noted that the surveyed code requires less physician work and time to perform and is thus appropriately valued lower. The RUC also compared the surveyed code to the second top key reference code 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch* (work RVU= 10.96, 76 minutes of intra-service time and 135 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and time required to perform these services. Being that the surveyed code is a bilateral procedure for a patient with abnormal connections, there is increased intra-service, in addition to a greater intensity of physician work required. Therefore, the RUC determined that a higher work RVU would be appropriate relative to the other codes in this family. This valuation is consistent with the supporting key reference codes and comparable to the median from the survey results.

For additional support, the RUC referenced CPT code 33745 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt* (work RVU= 20.00, 92 minutes intra-service time, and 207 minutes of total time). The RUC reviewed the differences in intra-service time and intensity of physician work and determined that the total time required to perform this service and the longer skin-to-skin time warrant a similar RVU. **Therefore, the RUC recommends a work RVU of 20.00 for CPT code 338X6.**

338X7 Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (list separately in addition to code for primary procedure)

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 7.27 for CPT code 338X7. The RUC recommends 45 minutes of intra-service for each additional stent. It is important to note that the work of this procedure is supplementary to the work related to the primary services from this code family and should be used for the additional work related to stent placement of each additional vessel or separate lesion (normal or abnormal) of percutaneous pulmonary artery revascularization.

To justify the value of 7.27, the RUC compared the surveyed code to CPT code 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)* (work RVU= 8.00 and 60 minutes of intra-service time/total time) and determined that the surveyed code appropriately relates to this service based on the intensity of physician work and intra-service time required to perform these services.

For additional support, the RUC referenced CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00 and 60 minutes of intra-service time). The RUC recognized similarities in the intensity of physician work for these services despite differences in intra-service time;

ultimately, this comparison was determined to be in line with the survey results and supports the proposed work RVU. **The RUC recommends a work RVU of 7.27 for CPT code 338X7.**

Practice Expense

No direct practice expense inputs are recommended for CPT codes 338X3-338X7 as they are facility-only services.

New Technology/New Service

The RUC recommends that CPT codes 338X3-338X7 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Somatic Nerve Injections (Tab 5)

Curtis Anderson, MD (SIR), Brooke Bisbee, DPM (APMA), Neal Cohen, MD (ASA), Lauren Golding, MD (ASA), Jon Hathaway, MD, PhD, (ACOG), Westley Ibazebo, MD (SIS), Minhaj Khaja, MD (SIR), Michael Lubrano, MD (ASIPP), Carlo Milano, MD (AAPMR), Gordon Morewood, MD (ASA), Andy Moriarity, MD (ACR), Gregory Polston, MD (AAPM), David Reece, DO (AAPMR) and Richard Rosenquist, MD (ASA)

In October 2015, CPT code 76942 was identified under the high volume growth screen and the RUC noted to review the utilization in October 2017. In October 2017, this code appeared on an agenda tab, but it was not surveyed. Therefore, the RUC indicated that this service was not addressed via this flag because the Relativity Assessment Workgroup (RAW) thought it was going to be addressed from the RUC survey process. In January 2018, the RAW reviewed this issue and noted that this service was recently bundled in 2015 and the clinical staff time is not duplicative.

In May 2018, the CPT Editorial Panel approved the revision of descriptors and guidelines for codes 64400-64450 and deletion of three codes to clarify reporting (i.e., separate reporting of imaging guidance, number of units, change of CPT codes 64421 from a 000-day global to ZZZ). Codes 64400-64450 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code. Image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately. The physician work for this family of services varies based on the anatomic location of each nerve, whether the service is typically performed in the facility setting, the typical approach used by the dominant specialty to access the nerve that performs each service and whether the service involves continuous infusion by catheter.

During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 50 percent of the time. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the CPT 2021 cycle. This overlap was accounted for in the RUC recommendations for these services. The RUC referred CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942, to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completed its work.

In May 2021, the CPT Editorial Panel approved the revision of ten codes to add “including imaging guidance, when performed” to the descriptors and to revise the introductory guidelines to report these

services. CPT codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 are now bundled and the parenthetical appropriately notes “Do not report in conjunction with 76942, 77002, 77003.”

Bundled Injection Codes

The RUC discussed the time and intensity for CPT codes 64415-64417 and 64445-64448 for the survey 25th percentile work RVU recommendations. The RUC noted decreases in the intra-service time for some of the codes and discussed that in general when surveying these codes with imaging now bundled, they would not expect the intra-service time to significantly increase because the imaging and injection physician work are occurring simultaneously. Similarly, the RUC considered the increased intensity of the surveyed codes and noted it is appropriate because the surveyed codes describe the physician work of doing both the injection and imaging simultaneously, wherein the previous codes only described the physician work of doing the injection alone. In reviewing the intensity, the RUC concluded that it provided further support for the appropriateness of the recommendations at the 25th percentile.

During the discussion of the bundled injection codes, the RUC questioned if it would be typical that an anesthesia code would be reported on the same date by the same physician and the specialty clarified that it should not be typical.

64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed

The RUC reviewed the survey results from 86 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.50 for CPT code 64415, noting that the brachial plexus injection requires more work than axillary, sciatic and femoral nerve injection without continuous infusion by catheter codes. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 4 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time, and 7 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.50, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted that the codes have identical intra-service and total times, yet the reference code involves less intense physician work. Similarly, of the survey respondents that selected this key reference service, 65% indicated that the surveyed code was more intense and complex. Therefore, 64415 is appropriately valued higher than the top key reference code.

The RUC also compared 64415 to the second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.80, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and less total time than the reference code and therefore is appropriately valued lower. The RUC further noted that the key reference services appropriately bracket the surveyed code. The RUC concluded that CPT code 64415 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.50 for CPT code 64415.**

64416 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

The RUC reviewed the survey results from 79 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.80 for CPT code 64416, noting that the brachial plexus injection requires more work than the axillary, sciatic and femoral nerve injection without continuous infusion by catheter codes and that the additional 5 minutes of intra-service time for the catheter placement is appropriate. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 10 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.80, the RUC compared the surveyed code to the top key reference code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the codes have identical intra-service times and similar total times, yet the surveyed code involves less intense physician work and is therefore appropriately valued lower than the top key reference code.

The RUC also noted the close comparison of 64416 to the second highest key reference code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time). The codes have identical intra-service times and similar total times, yet the surveyed code involves slightly less intense physician work and therefore is appropriately valued slightly lower than the reference code.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64416 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.80 for CPT code 64416.**

64417 Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed

The RUC reviewed the survey results from 79 anesthesiologists and interventional pain physicians and determined that the survey 25th percentile work RVU of 1.31 for CPT code 64417 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 4 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time, and 10 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-

service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.31, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted the close comparison with identical intra-service times, similar total times and intensity, and comparable amount of physician work. The RUC also compared 64417 to the second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.80, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and involves less intense physician work than the reference code and therefore is appropriately valued lower.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64417 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.31 for CPT code 64417.**

64445 *Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed*

The RUC reviewed the survey results from 76 anesthesiologists and interventional pain physicians and determined that the survey 25th percentile work RVU of 1.39 for CPT code 64445 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 7 minutes pre-service evaluation, 1 minute pre-service positioning, 1 minute pre-service scrub/dress/wait time, 10 minutes intra-service time, and 5 minutes immediate post-service time.

To support a work value of 1.39, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted that the codes have identical intra-service times, yet the surveyed code involves more intense physician work focused on the sciatic nerve. Similarly, of the survey respondents that selected this key reference service, 96% indicated that the surveyed code was identical or more intense and complex relative to the key reference service. Therefore, 64445 is appropriately valued higher than the top key reference code.

The RUC also compared 64445 to the second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU

= 1.80, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and less total time than the reference code and therefore is appropriately valued lower. The RUC further noted that the key reference services appropriately bracket the surveyed code. The RUC concluded that CPT code 64445 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.39 for CPT code 64445.**

64446 Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

The RUC reviewed the survey results from 60 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.75 for CPT code 64446, noting that the additional 5 minutes of intra-service time for the catheter placement is appropriate. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 10 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.75, the RUC compared the surveyed code to both the top key reference code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and the second highest key reference code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that, in both cases, the codes have identical intra-service times, yet the surveyed code involves less intense physician work and therefore is appropriately valued lower than the reference codes.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64446 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.75 for CPT code 64446.**

64447 Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed

The RUC reviewed the survey results from 76 anesthesiologists and interventional pain physicians and determined that the survey 25th percentile work RVU of 1.34 for CPT code 64447 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 12 minutes pre-service evaluation, 1 minute pre-service positioning, 3 minutes pre-service scrub/dress/wait time, 8 minutes intra-service time, and 5 minutes immediate

post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.34, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time than the reference code and involves more intense physician work next to a major vessel and nerve as opposed to the abdominis plane. Therefore, 64447 is appropriately valued higher than the top reference code. Similarly, of the survey respondents that selected this top key reference service, 97% indicated that the surveyed code was identical or more intense and complex relative to the reference service.

The RUC also compared 64447 to the second highest key reference code 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU = 1.52, 17 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and less total time than the reference code and therefore is appropriately valued lower. The RUC further noted that the key reference services appropriately bracket the surveyed code. The RUC concluded that CPT code 64447 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.34 for CPT code 64447.**

64448 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed*

The RUC reviewed the survey results from 62 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.68 for CPT code 64448, noting that the additional 7 minutes of intra-service time for the catheter placement is appropriate. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 9 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.68, the RUC compared the surveyed code to both the top key reference code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and the second highest key reference code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that, in both cases, the codes have identical intra-service times and similar total times, yet the surveyed code involves less intense physician work and therefore is appropriately valued lower than the reference codes.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee,*

subacromial bursa); with ultrasound guidance, with permanent recording and reporting (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64448 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.68 for CPT code 64448.**

Imaging Codes

There are three codes which capture the imaging guidance component of the somatic nerve injection procedures that will no longer be reported separately with codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448, as their work is now bundled into each revised CPT code.

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

The RUC reviewed the survey results from 98 physicians and determined that maintaining the current work RVU of 0.67, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 7 minutes pre-service evaluation time, 15 minutes intra-service time, and 5 minutes immediate post-service time as supported by the survey.

The RUC compared CPT code 76942 to the top key reference code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56, 10 minutes intra-service time and 18 minutes total time) and noted that the surveyed code has 5 minutes more intra-service time and more total time than the top key reference code and therefore is appropriately valued higher. The reference service is a comparable ultrasound procedure based on the type of imaging performed and the interpretation of the images obtained. Comparatively, the surveyed code typically requires more pre-service time to review the pre-existing images for the needle target and more real-time imaging to guide the needle during the procedure. This contributes to the 5 additional intra-service minutes and overall greater total time for 76942, along with higher value relative to the top key reference service.

The RUC also compared 76942 to the second highest key reference code 38221 *Diagnostic bone marrow; biopsy(ies)* (work RVU = 1.28-, and 20-minutes intra-service time and 50 minutes total time) which is a biopsy procedure performed without imaging guidance and noted that the surveyed code is appropriately valued lower given it has less intra-service time, less total time and involves less intense physician work than the reference service.

For additional support, the RUC compared CPT code 76942 to MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70, 2 minutes pre-service evaluation time, 15 minutes intra-service time and 3 minutes immediate post-service time) and noted that the codes have identical intra-service times yet the multi-specialty points of comparison code involves slightly more intense physician work than the surveyed code, justifying the recommendation. The RUC concluded that the value of CPT code 76942 should be maintained at 0.67 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 0.67 for CPT code 76942.**

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 91 physicians and determined that maintaining the current work RVU of 0.54 appropriately accounts for the physician work involved in this add-on service, which is supported by the survey 25th percentile work RVU. The RUC recommends the following physician time components: 2 minutes pre-service positioning time, 15 minutes intra-service time, and 0 minutes post-service time.

CPT codes 77002 and 77003 were once XXX global period codes, but CMS determined that the vignettes and parentheticals for these codes were consistent with that of add-on codes and requested that the societies survey them as ZZZ codes in October 2015. At that time, the existing times for both 77002 and 77003 were 7 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service. At the October 2015 meeting, the RUC recommended reducing the pre-service time to 2 minutes instead of 7 minutes. The 2 minutes of pre-service time is based on the difference in pre-service positioning time between the epidural injection without imaging guidance (CPT code 62320) and with imaging guidance (CPT code 62321) codes. This is the reason why these add-on services include pre-service time.

The RUC compared CPT code 77002 to the top key reference code 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* (work RVU = 0.38, 2 minutes pre-service positioning time, 15 minutes intra-service time and 0 minutes immediate post-service time) and noted that the add-on codes have the exact same times, including 2 minutes for pre-service positioning, yet the surveyed code involves more intense physician work and therefore is appropriately valued higher than the reference code. CPT code 77002 pertains to fluoroscopic guidance for needle placement during a percutaneous procedure and typically may involve contrast injection or tissue sampling to aid in confirming the position. Comparatively, the reference service involves fluoroscopic guidance through an existing venous access.

The RUC also compared 77002 to the second highest key reference code 10008 *Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU = 1.18, 20 minutes intra-service time) which is an ultrasound guidance code that typically involves tissue sampling, and noted that the surveyed code is appropriately valued lower given it has less intra-service time and involves less intense physician work than the reference service. The RUC concluded that the value of CPT code 77002 should be maintained at 0.54 work RVUs as supported by the survey. **The RUC recommends a work RVU of 0.54 for CPT code 77002.**

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 82 physicians and determined that maintaining the current work RVU of 0.60, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this add-on service. The RUC recommends the following physician time components: 2 minutes pre-service positioning time, 15 minutes intra-service time, and 0 minutes post-service time.

CPT codes 77002 and 77003 were once XXX global period codes, but CMS determined that the vignettes and parentheticals for these codes were consistent with that of add-on codes and requested

that the societies survey them as ZZZ codes in October 2015. At that time, the existing times for both 77002 and 77003 were 7 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service. At the October 2015 meeting, the RUC recommended reducing the pre-service time to 2 minutes instead of 7 minutes. The 2 minutes of pre-service time is based on the difference in pre-service positioning time between the epidural injection without imaging guidance (CPT code 62320) and with imaging guidance (CPT code 62321) codes. This is the reason why these add-on services include pre-service time.

The RUC compared CPT code 77003 to the top key reference code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00, 10 minutes intra-service time) and noted that the surveyed code has more intra-service time but involves much less intense physician work and therefore is appropriately valued lower than the top key reference service which must target a smaller transforaminal approach compared to the epidural or subarachnoid localization. The RUC also compared 77003 to the second highest key reference 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, 15 minutes intra-service time) and noted that the add-on codes have identical intra-service times, yet the surveyed code again involves less intense physician work and is appropriately valued lower than the reference service. The RUC concluded that the value of CPT code 77003 should be maintained at 0.60 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 0.60 for CPT code 77003.**

Affirmation of RUC Recommendations

The RUC reviewed the specialty societies' request to affirm the recent RUC valuations for the remaining codes in the Somatic Nerve Injections tab. Although these codes were identified with the other codes to be surveyed, the specialty societies elected not to survey because the codes were recently reviewed by the RUC and, unlike 64415-64417 and 64445-64448, there were no changes to their code descriptors. The RUC agreed to affirm the recommendations for the fourteen remaining codes. **The RUC recommends affirming the following recent RUC-recommended work RVUs:**

1.00 for CPT code 64400	1.15 for CPT code 64430
0.94 for CPT code 64405	0.75 for CPT code 64435
0.90 for CPT code 64408	1.55 for CPT code 64449
1.10 for CPT code 64418	0.75 for CPT code 64450
1.18 for CPT code 64420	1.52 for CPT code 64451
0.60 for CPT code 64421	1.52 for CPT code 64454
1.19 for CPT code 64425	0.75 for CPT code 64455

Practice Expense

Although not required due to the bundling of the codes, the specialty societies chose to address compelling evidence to support the direct practice expense recommendations. The Practice Expense (PE) Subcommittee discussed that these codes were previously reported without imaging and now include imaging, which constitutes the compelling evidence. It is the bundling of two codes into a single code. Further, the PE Subcommittee noted that the corresponding imaging code 76942 shows a net savings for each bundled code. The PE Subcommittee voted to approve compelling evidence for CPT codes 64415-64417 and 64445-64448. In addition, the PE Subcommittee verified the equipment minutes as submitted. The PE Subcommittee also voted to approve compelling evidence for CPT codes 76942, 77002 and 77003 to account for the updated calculation of equipment time for ED050 *Technologist PACS workstation* for CPT code 76942 and the addition of ED053 *Professional PACS*

workstation for CPT codes 77002 and 77003. The previous omission of the Professional PACS workstation was in error. **The RUC recommends the direct practice expense inputs as submitted by the specialty society on all three PE spreadsheets.**

Potential Misreporting

For CPT codes 64445 and 64447, the RUC database indicates that family physicians are the dominant specialty in the non-facility setting, reporting at 36% and 57% respectively. The reporting of these services by family physicians was confusing since these are not procedures that would typically be provided by non-anesthesiologists. Upon further research, the specialties have determined that the family medicine non-facility reporting these services are likely a result of inappropriate reporting. The public 2019 Physician Supplier Procedure Summary (PSPS) file was analyzed, and it was found that family medicine physicians in Fort Worth, Texas were responsible for 64% of all claims for CPT code 64445 and 89% of all claims for CPT code 64447. The large concentration of family medicine non-facility claims in one locality suggests potential misreporting. **The RUC suggests that CMS explore and address this misreporting.**

Work Neutrality

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

Transcutaneous Passive Implant-Temporal Bone (Tab 6)

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

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

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

At the April 2021 RUC meeting, the RUC recommended temporarily affirming the January 2021 interim RUC recommendations for work and practice expense inputs for CPT codes 69714, 69716, 69717, 69719, 69726, and 69727 and resurveying these codes for the October 2021 RUC meeting following revisions at the May 2021 CPT Editorial Panel meeting. In May 2021, for CPT 2023, the CPT Editorial Panel established three new codes 69XX0, 69XX1, 69XX2 and added a parenthetical note reporting transcutaneous, passive bone anchored implants for bone conduction hearing appliances.

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

The RUC recommends that CPT codes 69714, 69716, 69717, 69719, 69726, 69727, 69XX0, 69XX1, and 69XX2 be resurveyed for January 2022, and that the specialty society work with the Research Subcommittee to draft a valid survey.

Pulmonary Angiography (Tab 8)

Mark Hoyer, MD (SCAI), Afnan Tariq, MD (SCAI), Edward Toggart, MD, Edward Touhy, MD (ACC), Thad Waites, MD (ACC) and Richard Wright, MD (ACC)

In May 2021, the CPT Editorial Panel revised CPT code 93568 to include “nonselective” and “arterial” in its long descriptor and created four new Category I CPT Codes to report injection procedure during cardiac catheterization including imaging supervision, interpretation, and reporting for selective pulmonary arterial angiograph (unilateral and bilateral) and for selective pulmonary angiography of each distinct pulmonary vein and from an arterial approach. CPT add-on codes 93563-93567 were surveyed as part of the same code family for the October 2021 RUC meeting.

Compelling Evidence

The RUC reviewed and agreed that there is compelling evidence based on a change in the patient population, prior incorrect assumptions, and a change in technology/technique. The specialty noted that pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. The prior version of CPT code 93568, with the long descriptor stating *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)*, was created to describe pulmonary angiography with congenital, as well as non-congenital cardiac catheterization. It does not distinguish between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code does not capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient.

Incorrect Assumptions The prior survey for 93568 included only traditional interventional cardiologists and had a vignette that was not explicitly for a pediatric patient. No pediatric/congenital interventional cardiologists were explicitly included in the prior survey even though the typical patient for selective pulmonary angiography is a pediatric patient. These services are predominantly performed by physicians who were not included in the prior survey.

Change in Technique Complex angiographic techniques have been performed for decades to delineate the pulmonary anatomy yet only a single general pulmonary angiography code was available to capture the work of both non-selective and selective pulmonary angiography. Pulmonary veins and Major Aortopulmonary Collateral Arteries (MAPCAs) were not considered when 93568 was created. For example, the submitted article by Soquet, et al. describes the change in management of pulmonary atresia with ventricular septal defect that require information gleaned by pulmonary angiography, and Adamson, et al. articulate the complexity of managing patients with tetralogy of Fallot and MAPCAs. Additionally, Cory, et al. chronicle the evolution of techniques used to treat pediatric pulmonary vein stenosis.

Change in Patient Population The specialty societies noted, and the RUC agreed, that diagnostic catheter studies were performed in children who were relatively healthier with simpler cardiac defects when the previous code structure was last valued a decade ago; children with more significant cardiac defects had fewer treatment options. As result of improvements in both technique and technology, the specialty has evolved, and the typical patient is now more complex.

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The RUC concurred that there is compelling evidence that the physician work for these services has changed due to prior incorrect assumptions, change in technology/technique and a change in patient population.

93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 1.11 for CPT code 93563, below the survey 25th percentile. The RUC recommends 15 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC recommended 2.00 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at that time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation; the recommended physician time was implemented as well. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 1.11, the RUC compared the surveyed code to the second key reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.38, intra-service and total time of 15 minutes) and noted that both services involve an identical amount of time. The RUC also compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service and total time of 15 minutes) and noted that both services involve an identical amount of time and involve a similar amount of physician work. The RUC's recommendation assigns this service a physician work intensity that is below both key reference services. **The RUC recommends a work RVU of 1.11 for CPT code 93563.**

93564 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 25 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 1.13 for CPT code 93564, below the survey 25th percentile. CPT code 93564 did not reach the 30-survey response threshold and will be re-reviewed in three years by the Relativity Assessment Workgroup. At that time, specialty societies will submit an action plan indicating whether this service should either be resurveyed or referred to the CPT Editorial Panel for subsequent deletion or revision to a Category III code. The RUC recommends 18 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 2.10 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 1.13, the RUC compared the surveyed code to the second key reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.38, intra-service and total time of 15 minutes) and noted that the surveyed code involves somewhat more time to perform. The RUC also compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service and total time of 15 minutes) and noted that the surveyed code involves more time, though both services involve a similar amount of physician work. The RUC's recommendation assigns this service a physician work intensity that is below both key reference services. **The RUC recommends a work RVU of 1.13 for CPT code 93564.**

93565 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)*

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.86 for CPT code 93565, below the survey 25th percentile. The RUC recommends 10 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 1.90 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 0.86, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List*

separately in addition to code for primary procedure) (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that with one less minute of intra-service time, the surveyed code is appropriately valued somewhat lower than this reference code which has a similar work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 0.86 for CPT code 93565.**

93566 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 34 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.86 for CPT code 93566, below the survey 25th percentile. The RUC recommends 10 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 0.96 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was lower than the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 0.86, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that with one less minute of intra-service time, the surveyed code is appropriately valued somewhat lower than this reference code which has a similar work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 0.86 for CPT code 93566.**

93567 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 34 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.97 for CPT code 93567, below the survey 25th percentile. The RUC recommends 10 minutes of intra-service and total time for this add-on service.

The specialties noted that, relative to CPT codes 93565 and 93566 which also typically involve 10 minutes of time, 93567 is a more intense service to perform. CPT code 93567 is typically provided to a relatively sicker and older adult population compared to codes 93565 and 93566, due to there being a greater risk of rupture and catheter passes are more tortuous in the senior population. There is a higher likelihood of a calcified aorta and risk for the dislocation of aortic plaque. Finally, when

working in the aorta, extra care must be taken to avoid the iatrogenic introduction of air into the vasculature.

To justify a value of 0.97, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that though the surveyed code typically involves one less minute of intra-service time, it is a slightly more intense service to perform; it is warranted to have both services have a similar valuation. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. The RUC concluded that the value of CPT code 93567 should be maintained at 0.97 RVUs as previously accepted by CMS and supported by the current survey. **The RUC recommends a work RVU of 0.97 for CPT code 93567.**

93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure)*

The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.88 for CPT code 93568, below the survey 25th percentile. The RUC recommends 13 minutes of intra-service and total time for this add-on service. The CPT Editorial Panel revised CPT code 93568 to include “nonselective” and “arterial” in its long descriptor. It was noted that although the prior version of 93568 did not specifically state “non-selective” or “arterial”, the previous surveyed typical patient with dyspnea and echocardiographic findings would most commonly only require non-selective pulmonary arterial angiography.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 0.96 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was lower than the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 0.88, the RUC compared the surveyed code to the second key reference code 93561 *Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)* (work RVU= 0.95, intra-service and total time of 15 minutes) and noted that the surveyed code involves somewhat less time to perform and therefore it would be appropriate to assign it a somewhat lower valuation. The RUC also compared the surveyed code to reference code 15274 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 0.80, intra-service and total time of 10 minutes) and noted that the surveyed code involves 3 more minutes of

total time, justifying the higher valuation. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 0.88 for CPT code 93568.**

93XX0 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 32 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.05 for CPT code 93XX0. The RUC recommends 11 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93XX0, 93XX1, 93XX2, 93XX3) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography, 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

To justify a work RVU of 1.05, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that the surveyed code involves one more minute of time and should be assigned a slightly higher work value. The RUC also compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves less time to perform and less physician work, justifying a lower valuation than the top key reference service. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.05 for CPT code 93XX0.**

93XX1 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 33 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.75 for CPT code 93XX1. The RUC recommends 18 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93XX0, 93XX1, 93XX2, 93XX3) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

To justify a work RVU of 1.75, the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 3 more minutes of total time and is less intense to perform, supporting the proposed value. The RUC also compared the surveyed code 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 and total time of 20 minutes) and noted that although the surveyed code involves less time, it involves a moderately higher physician work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.75 for CPT code 93XX1.**

93XX2 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization. (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 32 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.84 for CPT code 93XX2. The RUC recommends 20 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93XX0, 93XX1, 93XX2, 93XX3) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography, 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

The RUC noted that CPT code 93XX2 can be reported in multiple units for each distinct pulmonary vein during cardiac catheterization, and that there are typically 4 pulmonary veins, though for some patients it could be 3 or 5 pulmonary veins. The specialty societies noted that each patient would not have angiography performed in all their pulmonary veins, and that typically only veins where the provider has a suspicion from a previous non-invasive study would be studied. The specialty societies also noted that it would be relatively rare to perform this service on 4 or 5 pulmonary veins. In addition, the specialties indicated that the same type of catheter could not be used for multiple pulmonary veins and would need to be switched out for a different shape of catheter or a different wire combination. The specialties noted, and the RUC concurred, that the previous version of code 93568 did not appropriately capture all the time-intensive and relatively intense physician work involved for selective pulmonary venous angiography.

To justify a work RVU of 1.84, the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 5 more minutes of total time and less intense physician work, supporting the proposed lower value. The RUC also compared the surveyed code 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 and total time of 20 minutes) and noted that although both services typically involve an identical amount of time, the surveyed code is a more intense service to perform. The reference service is typically performed on an adult patient and under only local anesthesia, whereas the surveyed code is typically performed on a highly complex pediatric patient. The vignette for 93XX2, that 100 percent of the survey respondents found to be typical, was: "During a diagnostic cardiac catheterization, a 6-month-old male with down syndrome, status post atrioventricular (av) canal repair with new pulmonary hypertension undergoes multiple selective pulmonary venous angiograms to evaluate for presence of any pulmonary vein stenosis". The RUC's

recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.84 for CPT code 93XX2.**

93XX3 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, each distinct vessel

The RUC reviewed the survey results from 33 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.92 for CPT code 93XX3. The RUC recommends 20 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93XX0, 93XX1, 93XX2, 93XX3) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography, 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

Patients with pulmonary atresia and absent connection often have alternate, non-native, sources of pulmonary blood flow, and it becomes important for the pediatric interventional cardiologist to define those and detail those sources of pulmonary blood flow. Major Aortopulmonary Collateral Arteries (or MAPCAs) are arteries that develop to supply blood to the lungs when native pulmonary circulation is underdeveloped. A patient could have anywhere from only 1 to up to 12 MAPCAs. MAPCAs are tortuous and considerable anatomic variety — they can be small or large at their origin. Selecting different catheters going into and out of each one and getting into them is very time-intensive, complicated and involves intense physician work.

To justify a work RVU of 1.92, the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 5 more minutes of total time and less intense physician work, supporting the proposed lower value. Similarly, 86 percent of the survey respondents that selected 36227 as their top key reference code indicated that the surveyed code is in fact a more intense service to perform. The RUC also compared the surveyed code to 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 of intra-service and total time) and noted that both services would have appropriate relativity with the RUC's recommendation for 93XX3. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.92 for CPT code 93XX3.**

Practice Expense

No direct practice expense inputs are recommended for CPT codes 93563-93568 and 93XX0-93XX3 as they are facility-based add-on services.

New Technology/New Service

The RUC recommends that CPT codes 93XX0, 93XX1, 93XX2 and 93XX3 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

RAW Flag for Service with Less than 30 Survey Responses

CPT code 93564 did not reach the 30-survey response threshold and will be re-reviewed in three years by the Relativity Assessment Workgroup. At that time, specialty societies will submit an action plan indicating whether this service should either be resurveyed or referred to the CPT Editorial Panel for subsequent deletion or revision to a Category III code.

Do Not Use to Validate for Physician Work

The RUC agreed that CPT code 93564 should continue to be labeled in the RUC database with a flag that it should not be used to validate physician work, as the survey for this service did not achieve 30 survey respondents.

Quantitative Pupillometry Services (Tab 9)

David Glasser, MD (AAO), Steven Krug, MD (AAP), Ankoor Shah, MD (AAO) and Debra Weese-Mayer, MD (AAP)

The CPT Editorial Panel approved a new Category I CPT code to replace the sunset Category III CPT code 0341T *Quantitative pupillometry with interpretation and report, unilateral or bilateral* and 92499 *Unlisted ophthalmological service or procedure* for reporting this service. Code 0341T was sunset within the *CPT 2020* code set and instruction was included in a parenthetical cross-reference directing use of unlisted code 92499 when quantitative pupillometry was provided. CPT code 959XX was surveyed for the October 2021 RUC meeting.

Code 959XX identifies unilateral or bilateral quantitative pupillometry. This service provides non-invasive measurements of autonomic nervous system function that inform objective quantification of pupillary response to light. The holistic interpretation of this collected information can be effectively applied to many disorders in adults, children, and infants; a physician can ascertain details of sympathetic and parasympathetic function based on the interpretation and documentation of this service. The specialty societies noted that while the data is collected by a technician, the data is analyzed and assessed by a physician or another qualified health care (QHC) professional.

959XX Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral

The RUC reviewed the survey results from 36 physicians and recommends the survey 25th percentile work RVU of 0.25 for CPT code 959XX. The RUC recommends 1 minute of pre-service evaluation time, 5 minutes of intra-service time and 1 minute of immediate post-service time. The specialties noted that the 5 minutes of intra-service time includes time to conduct an extensive review and interpretation of the collected data; the physician will review individual wave forms, compare each data point to published normative measures by age, check for asymmetric or unique patterns, check for consistency across sympathetic tones, and complete a report that draws in other correlations and intervention recommendations. Therefore, the RUC determined that 5 minutes of intra-service time is appropriate for this comprehensive review and reporting.

The RUC compared the surveyed code to the top key reference service (KRS) 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30 and 10 minutes total time) and determined that the surveyed code RVU is valued appropriately lower, specifically in terms of the amount of time allocated for intra-service review. The RUC compared the surveyed code to the second top KRS 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey*

visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2 (work RVU = 0.50 and 13 minutes total time) determined that the surveyed code requires less physician work and total time than CPT code 92083, and thus is valued appropriately lower at approximately half the work RVU value.

CPT code 92202 *Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral* (work RVU= 0.26, 5 minutes of intra-service time and 7 minutes total time) was identified as an optimal comparison to CPT code 959XX due to identical intra-service time and total time. Additionally, the physician work required to perform this service is comparable, and therefore should be valued similarly to maintain relativity. For additional support, the RUC referenced CPT code 72190 *Radiologic examination, pelvis; complete, minimum of 3 views* (work RVU= 0.25, 5 minutes of intra-service time, and 7 minutes of total time) requires the same amount of time and has an identical work RVU and thus should be valued similarly. **The RUC recommends a work RVU of 0.25 for CPT code 959XX.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Service

The RUC recommends that CPT code 959XX be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Inpatient and Observation Care Services (Tab 10)

Megan Adamson, MD (AAFP), Charles Crecelius, MD, PhD (AGS), Charles Hamori, MD (ACP), Jon Hathaway, MD, PhD (ACOG), Michael Perskin, MD (AGS), Matthew Sideman, MD (SVS), Edward Tuohy, MD (ACC); Korinne Van Keuren, DNP, APRN (ANA), Thad Waites (ACC), Richard Wright, MD (ACC) and Robert Zipper, MD (SHM)

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

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

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

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

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services. The specialty societies will revise their survey instrument by working with the Research Subcommittee. **The RUC will review the inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2022 RUC meeting.**

Consultations (Tab 11)

Patrica Garcia, MD (AGA), Kano Mayer, MD (NASS), Phillip Rodgers, MD (AAHPM), Don Selzer, MD (ACS), Matthew Sideman, MD (SVS), Marianna Spanaki, MD, PhD (AAN), Karin Swartz, MD (AAN) and Richard Wright, MD (ACC)

Facilitation Committee #1

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

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

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

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient consultation or outpatient consultation code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing the patient are summed to select the appropriate code. The inpatient consultation and outpatient consultation services were surveyed for the October 2021 RUC meeting. The inpatient consultation survey time captured the total time on the date of encounter by calendar date. Aligning with the 2019 office visit survey process, the office or other outpatient consultation survey time captured includes pre-service time 3-days before the date of encounter, intra-service time is all the time on the date of encounter and post-service time is 7-days after the date of encounter.

Office or Other Outpatient Consultations

Although the recommended work RVUs for codes 99242-99245 are not greater than the current values, the specialty societies noted, and the RUC agreed that the compelling evidence of change in technology that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for office consultation codes. Specifically, According to National Medical Ambulatory Care Survey (NAMCS) data, in 2015, 76% of all practices used electronic health records exclusively, 11% used them partially, and 12% used only paper records. In 2008 the corresponding numbers were 29%, 17%, and 53%. All remarkable differences demonstrating that the technology used to deliver office-based care has changed dramatically. This is confirmed by the CDC, which estimates that use of an EHR increased from 35% in 2007 to 87% in 2015. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug and, with increasing use of homeopathic substances, drug substance interactions. In addition, the presenters provided information that consultations carry more liability due to the expert opinion provided. Since the inception of the Medicare Physician Fee Schedule, the work RVUs for the office consultation codes have always been higher than the office visit E/M codes; the Harvard study acknowledged a relative difference in work in 1991 and the RUC confirmed a relative difference in work in 2006.

99242 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

The RUC reviewed the survey results from 213 physicians and other qualified health care professionals and determined the survey median work RVU of 1.08 appropriately accounts for the physician work required to perform this service. The RUC recommends 30 minutes total time. The RUC noted that CPT code 99241 has been deleted and some or all its previous utilization will now be reported with CPT code 99242. The 2009 Medicare utilization of CPT code 99241 was only 21 percent of that of the Medicare utilization for 99242, thus the typical patient for a 99242 will not change.

The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests.

To justify a work RVU of 1.08, the RUC compared the surveyed code to the top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 20 minutes total time) and determined that CPT code 99242 typically requires more physician work and time, thus would be valued appropriately with a work value of 1.08. The RUC also compared the surveyed code to MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU= 1.30, 30 minutes total time) and noted that although both services involve an identical amount of total time, the surveyed code involves a lower level of medical decision making relative to the reference code (straightforward vs. low), and therefore would have appropriate relativity with this reference service.

The RUC recommends a work RVU of 1.08 for CPT code 99242.

99243 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

The RUC reviewed the survey results from 234 physicians and other qualified health care professionals and determined that the survey median work RVU of 1.80 appropriately accounts for the physician work required to perform this service. The RUC recommends 44 minutes total time.

The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests.

To justify a work RVU of 1.80, the RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 35 minutes total time) and determined that CPT code 99243 typically requires more physician work and time, thus would be valued appropriately higher with a work value of 1.80. The RUC also compared the surveyed code to the second top key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU= 1.30, 30 minutes total time) and noted that the surveyed code involves 14 more minutes of total time and both services are for a low level of medical decision making. In addition, surveyed code 99243 is typically for a new patient, whereas reference code 99213 is for an established patient. The RUC concurred that assigning 99243 a value of 1.80 would maintain relativity with the current value for 99213. **The RUC recommends a work RVU of 1.80 for CPT code 99243.**

99244 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

The RUC reviewed the survey results from 248 physicians and other qualified health care professionals and determined that a work RVU of 2.69, a value between the survey 25th percentile and survey median would most appropriately account for the physician work required to perform this service. The RUC recommends 60 minutes total time.

After thorough discussion, the RUC recommends a direct work RVU crosswalk to CPT code 93315 *Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report* (work RVU= 2.69, intra-service time of 40 minutes, total time of 65 minutes), agreeing that both services involve similar total time and similar relative physician work. The RUC also compared the surveyed code to top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes) and concurred that 99244 should be valued with a slightly higher intensity and higher work RVU relative to 99204 and referenced that 63 percent of the

survey respondents that selected this top key reference service had indicated that 99244 is more intense/complex.

The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests. The specialties also noted that a consultation typically involves a greater amount of data to review at the moderate level decision-making level relative to the analogous new patient office visit code 99204. The RUC concluded that CPT code 99244 should be valued based on a direct work RVU crosswalk to CPT code 93315 which falls between the median and 25th percentile as supported by the survey. **The RUC recommends a work RVU of 2.69 for CPT code 99244.**

99245 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

The RUC reviewed the survey results from 231 physicians and other qualified health care professionals and determined that the survey median work RVU of 3.75 appropriately accounts for the physician work required to perform this service. The RUC recommends 87 minutes total time.

To justify a work RVU of 3.75, the RUC compared the surveyed code to top key reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU= 3.50, total time of 88 minutes) and concurred that 99245 should be valued with a slightly higher intensity relative to 99205 and referenced that 67 percent of the survey respondents that selected this top key reference service had indicated that 99245 is more intense/complex. The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests. The specialties also noted that a consultation typically involves a greater amount of data to review at the high-level decision-making level relative to the analogous new patient office visit code 99205.

The RUC referenced CPT code 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)* (work RVU= 3.86, intra-service time of 55 minutes, total time of 75 minutes) and CPT code 44390 *Colonoscopy through stoma; with removal of foreign body(s)* (work RVU= 3.74, intra-service time of 35 minutes, total time of 77 minutes) and noted that the surveyed code involves more total time, though a similar amount of physician work to these reference services. **The RUC recommends a work RVU of 3.75 for CPT code 99245.**

Inpatient and Observation Consultations

In October 2021, the RUC referred the inpatient and observation consultation services to be resurveyed, because the survey did not include a request for distinct time before and after floor/unit

time, and therefore could not be compared to previous RUC surveys of these services. The specialty societies will revise their survey instrument by working with the Research Subcommittee. **The RUC will review the inpatient consultation services CPT codes 99252, 99253, 99254 and 99255 at the January 2022 RUC meeting.**

CPT Descriptor Time for Outpatient Consultations

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

CPT Code	Descriptor	Time on the Date of Encounter Recommendation to CPT
99242	Office or Other Outpatient Consultation, new or est pt, straightforward MDM	20
99243	Office or Other Outpatient Consultation, new or est pt, low MDM	30
99244	Office or Other Outpatient Consultation, new or est pt, moderate MDM	40
99245	Office or Other Outpatient Consultation, new or est pt, high MDM	55

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs for outpatient consultation and made no modifications. **The RUC recommends the outpatient consultation direct practice expense inputs as submitted by the specialty societies.** The practice expense for the inpatient consultation codes will be reviewed at the January 2022 RUC meeting.

Work Neutrality

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

Nursing Facility Discharge Day Services (Tab 12)

Audrey Chun, MD (AGS), Charles Crecelius, MD PhD (AMDA), Charles Hamori, MD (ACP), Carlo Milani, MD (AAPMR); Korinne Van Keuren, DNP, APRN (ANA), Elisabeth Volpert, DNP, APRN (ANA) and Brooke Bisbee, DPM (APMA)

Facilitation Committee #1

In April 2021, the RUC reviewed the initial and established patient nursing facility care services 99304-99310. At that time, when reviewing nursing facility discharge day services, CPT codes 99315 and 99316, the RUC determined these services should be reviewed with the hospital discharge day management codes, 99238 and 99239, in October 2021. Therefore, the RUC recommended to table review of CPT codes 99315 and 99316 until October 2021. However, at the October 2021 meeting, the hospital discharge day management codes 99238 and 99239 were postponed to be reviewed at the same time as the inpatient hospital and observation care codes, in January 2022. Upon further discussion of nursing facility discharge day services, the RUC determined that these services are distinct from the hospital discharge day management services and could be reviewed separate from the hospital discharge day management codes. As outlined in detail in the compelling evidence below, the nursing facility discharge day services are different due to management of the multiple

electronic medical records and changes in nursing home care. These services have clinically distinct workflows and different patient populations. Therefore, the RUC determined that the nursing facility discharge services could be reviewed separately from the inpatient hospital discharge day services.

Compelling Evidence

The specialty societies indicated that there is compelling evidence based on a change in physician work due to changes in technology, patient population, and length of stay.

Change in physician work due to technology, specifically the use of multiple EMRs

Nursing facilities were slow to integrate electronic medical records (EMRs) into their workflow, because EMRs are not well suited for nursing facilities. In addition, the typical EMR system at a nursing facility is not interoperable with EMRs at other places of service. Physicians and other qualified health care professionals (QHPs) need to review and extract data from the nursing facility EMR to integrate into their standard workflow and documentation, usually outpatient based EMRs. Similarly, when orders or other interventions are made, documentation needs to occur in both systems, the nursing facility and outpatient EMR, respectively. There are no EMRs in this space that integrate meaningfully. The typical computer of a physician or QHP working in the nursing facility setting will utilize multiple EMRs depending on the number of nursing facilities or skilled nursing facilities (SNFs) the individual works with. The necessary duplication of documentation across systems creates more provider work, especially on patient discharge, where problems such as medications and follow-up need to be reconciled, documented, and acted upon in two systems.

Change in physician work due to change in patient population and length of stay

Data supports that since the discharge codes were last reviewed in 2010, the length of stay in the nursing home has decreased. According to the March 2021 Medicare Payment Advisory Commission (MedPAC) Report to Congress, the number of covered days per admission in the SNF has decreased from 27.1 in 2010 to 24.8 in 2019, a decrease of 8.5%. This is coupled with shorter hospital stays and faster discharge from the nursing facility. Further, the March 2020 MedPAC Report to Congress includes data documenting mean risk-adjusted rates of community discharge have increased from 35.7% in 2012 to 41.4% in 2018, during which time readmits during the SNF stay decreased from 11.4 to 10.6%. This supporting evidence signals that more physician work is focused on discharging patients earlier and more often safely to home.

The acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. Data provided in the summary of recommendation (SOR) shows the increase in patient acuity upon hospital discharge (based on the Elixhauser Comorbidity Index, which is a method of categorizing comorbidities of patients based on the International Classification of Diseases) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing facility visits. The specialty societies also referenced multiple studies demonstrating changes in physician work due to increased complexity of the patient population.

The RUC concurred that there is compelling evidence that the physician work for these services has changed based on changes in technology and change in patient population and length of stay.

99315 Nursing facility discharge day management; 30 minutes or less

The RUC reviewed the survey results from 185 physicians and other qualified health care professionals and determined that the 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service evaluation

time, 25 minutes of intra-service time and 5 minutes of post-service time.

The RUC compared CPT code 99315 to nursing facility visit code 99304 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 1.50 and 25 minutes intra-service time) and determined that these services were surveyed by the same set of respondents in April 2021 and require the same intra-service time and similar total time, 40 and 36 minutes, respectively. The RUC noted that maintaining code 99315 at the current value of 1.28 would not be appropriate and would cause a rank order anomaly with 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 1.30 and 18 minutes intra-service time).

For additional support, the RUC referenced MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 25 minutes on the date of encounter time), MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes intra-service time), CPT code 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46 and 20 minutes intra-service time), CPT code 78830 *Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging* (work RVU = 1.49 and 25 minutes intra-service time) and 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* (work RVU = 1.46 and 20 minutes intra-service time), all which require similar physician work and time. The RUC concluded that CPT code 99315 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.50 for CPT code 99315.**

99316 Nursing facility discharge day management; more than 30 minutes

The RUC reviewed the survey results from 191 physicians and other QHPs and determined that the 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of pre-service evaluation time, 40 minutes of intra-service time and 8 minutes of post-service time.

The RUC compared CPT code 99316 to nursing facility visit code 99305 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 2.50 and 35 minutes intra-service time) and determined that these services were surveyed by the same set of respondents in April 2021 and require the similar intra-service time of 40 and 35 minutes and similar total time, 63 and 55 minutes, respectively. The RUC also compared 99316 to nursing facility visit code 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (April 2021 RUC recommended

work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and noted that if 99316 was maintained at the current value of 1.90, it would cause a rank order anomaly with the previously recommended value for moderate MDM subsequent nursing facility care code 99309.

For additional support, the RUC referenced MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 39 minutes intra-service time), CPT code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes intra-service time) and MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60 and 40 minutes intra-service time), all which require similar physician work and time. The RUC concluded that CPT code 99316 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.50 for CPT code 99316.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

Home and Residence Services (Tab 13)

Brooke Bisbee, DPM (APMA), Audrey Chun, MD (AGS), Michael Perskin, MD (AGS) and Korinne Van Keuren, DNP, APRN (ANA)

In February 2021, the CPT Editorial Panel deleted twelve of the domiciliary, rest home (e.g., boarding home) and custodial care services to merge these services with the home visit services. The eight revised codes describe home and residence services and align with the principles included in the office or other outpatient E/M office visits by documenting and selecting level of service based on total time or medical decision making.

In April 2021, the specialty societies surveyed the eight home and residence codes but did not obtain the required number of survey responses for the established patients (99347, 99348, 99349 and 99350). More importantly, responses from the predominant provider, such as nurse practitioners, for some of the services were not achieved (99344, 99345, 99349 and 99350). The specialty societies worked with the Research Subcommittee and developed a targeted survey sample methodology, using the Medicare Claims database to identify qualified healthcare professionals, focusing on nurse practitioners, who predominantly perform home visit services and matched them with societies to survey those individuals. The specialty societies also requested to limit the additional surveys to focus on obtaining valid responses from the predominant providers for codes 99344-99450. The Research Subcommittee approved the request to use a targeted survey sample in conjunction with their ongoing use of a random sample methodology. The RUC recommended that the home and residence services be postponed until October 2021 until valid responses were obtained.

New Patient

99341 Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

The RUC surveyed 93 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 6 minutes pre-service time, 15 minutes intra-service time and 6 minutes post-service time. The RUC noted that this service is currently performed by podiatrists 88% of the time based on 2019 Medicare utilization data, however, only 34% of the survey responses were from podiatrists. Therefore, the RUC recommends using the survey 25th percentile intra-service time of 15 minutes, instead of the median of 25 minutes. The 15 minutes of intra-service time is also the median intra-service time specified by the podiatrists who completed the survey. The RUC agreed that this adjustment in time represents a more appropriate intensity for this service. The RUC noted that podiatrists typically perform another CPT code in addition to these codes and any overlap in pre or post-service time would be reduced in the procedure code.

The RUC compared the surveyed code to the top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93 and 20 minutes total time) and determined that the home or residence visit requires somewhat more physician/QHP work and is more complex than the office visit because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 2 more minutes of total time relative to 99202.

The RUC compared the surveyed code to the second key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) and determined that the surveyed code is appropriately lower because it requires less time and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00 and 15 minutes intra-service time) and 91111 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report* (work RVU = 1.00 and 18 minutes intra-service time) as these services require the same physician work and similar time to perform. **The RUC recommends a work RVU of 1.00 for CPT code 99341.**

99342 *Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*

The RUC surveyed 97 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 1.65 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 10 minutes pre-service time, 32 minutes intra-service time and 10 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) and determined that the home or residence visit requires somewhat more physician/QHP work and is more complex than the office visit because the patient population is

more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 17 more minutes of total time relative to 99203.

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

For additional support, the RUC referenced CPT codes 76873 *Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)* (work RVU = 1.55 and 30 minutes intra-service time) and 95924 *Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt* (work RVU = 1.73 and 30 minutes intra-service time). **The RUC recommends a work RVU of 1.65 for CPT code 99342.**

99344 *Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.*

The RUC surveyed 72 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 2.87 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 15 minutes pre-service time, 60 minutes intra-service time and 17 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the office visit because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 32 more minutes of total time relative to 99204.

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

For additional support, the RUC referenced CPT codes 74712 *Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation* (work RVU = 3.00 and 60 minutes intra-service time), 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s)*

and further sequences; with stress imaging (work RVU = 3.00 and 60 minutes intra-service time), and 95912 Nerve conduction studies; 11-12 studies (work RVU = 3.00 and 60 minutes intra-service time) and noted that these services require the same intra-service time and similar work to perform. **The RUC recommends a work RVU of 2.87 for CPT code 99344.**

99345 Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

The RUC surveyed 72 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 3.88 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 25 minutes pre-service time, 74 minutes intra-service time and 27 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the office visit because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 38 more minutes of total time relative to 99205.

The RUC compared the surveyed code to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.* (work RVU = 4.50 and 40 minutes intra-service time) and determined that the surveyed code is appropriately lower because it is a less intense service and requires less work to perform.

For additional support, the RUC referenced CPT codes 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)* (work RVU = 3.86 and 55 minutes intra-service time) and 38240 *Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor* (work RVU = 4.00 and 60 minutes intra-service time) and noted that these services require similar physician work and time to perform and should be valued similarly. **The RUC recommends a work RVU of 3.88 for CPT code 99345.**

Established Patient

99347 Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

The RUC surveyed 84 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the physician or other qualified healthcare provider (QHP) work required to perform this service. The RUC recommends 5 minutes pre-service time, 20 minutes intra-service time and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU = 0.70 and 16 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 14 more minutes of total time relative to 99212.

The RUC compared the surveyed code to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes total time) and determined that, even though both services have identical total times, the surveyed code is appropriately valued lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU = 0.90 and 15 minutes intra-service time) and 93307 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography* (work RVU = 0.92 and 15 minutes intra-service time) and noted that these services require similar physician work and time to perform and should be valued similarly. **The RUC recommends a work RVU of 0.90 for CPT code 99347.**

99348 *Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*

The RUC surveyed 84 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 7 minutes pre-service time, 29 minutes intra-service time and 10 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 16 more minutes of total time relative to 99213.

The RUC compared the surveyed code to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.*

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. (work RVU = 1.92 and 47 minutes total time) and determined that the surveyed code is appropriately valued lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 72195 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)* (work RVU = 1.46 and 20 minutes intra-service time) and 78491 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU = 1.56 and 15 minutes intra-service time) and noted that these services require similar physician work and should be valued similarly **The RUC recommends a work RVU of 1.50 for CPT code 99348.**

99349 Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination moderate medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

The RUC surveyed 76 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 2.44 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 12 minutes pre-service time, 41 minutes intra-service time and 15 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 21 more minutes of total time relative to 99214.

The RUC compared the surveyed code to the second top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU = 2.80 and 70 minutes total time) and determined that the surveyed code is appropriately valued lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 39 minutes intra-service time) and CPT code 95718 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)* (work RVU = 2.50 and 35 minutes intra-service time). **The RUC recommends a work RVU of 2.44 for CPT code 99349.**

99350 Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination high medical decision making. When

using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

The RUC surveyed 75 physicians, podiatrists and nurse practitioners and determined that the survey median work RVU of 3.60 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 17 minutes pre-service time, 60 minutes intra-service time and 20 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU = 2.80 and 70 minutes total time) and determined that the home or residence visit requires more physician/QHP work, time and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 27 more minutes of total time relative to 99214.

The RUC compared the surveyed code to the second top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that the surveyed code requires the same level of medical decision-making, but requires slightly more time to perform, therefore is appropriately valued slightly higher. This service is the most intense of the home or residence services, these are patients who could reach hospital level care because they are hospital-adverse or because of the characteristics of their care goals, the plan is to keep them in the home environment.

For additional support, the RUC referenced CPT codes 75959 *Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation* (work RVU = 3.50 and 45 minutes intra-service time) and 50329 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each* (work RVU = 3.34 and 45 minutes intra-service time).

The RUC recommends a work RVU of 3.60 for CPT code 99350.

CPT Descriptor Time

The RUC recommends the following times for the CPT descriptors based on the survey medians. The times in the CPT descriptors were rounded from the survey intra-service time to be an increment between this family of services for the ease of those who may report these services based on time.

CPT Code	Descriptor	Time on the Date of Encounter Recommendation to CPT
99341	Home or residence visit new pt, straightforward MDM	15
99342	Home or residence visit new pt, low MDM	30
99344	Home or residence visit new pt, moderate MDM	60
99345	Home or residence visit new pt, high MDM	75
99347	Home or residence visit est pt, straightforward MDM	20
99348	Home or residence visit est pt, low MDM	30

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Approved by the RUC January 13, 2022

99349	Home or residence visit est pt, moderate MDM	40
99350	Home or residence visit est pt, high MDM	60

Practice Expense

The Practice Expense Subcommittee reviewed the non-facility direct practice expense inputs and adjusted the supplies for the typical patient by removing SM025 *specula tip, otoscope*, SK062 *patient education booklet* and SJ061 *tongue depressor* for established patient codes 99347, 99348, 99349 and 99350. The Subcommittee also made a revision to 99347 to remove the phone call for CA038 *Coordinate post-procedure services* reflecting the typical specialty (podiatry). **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.

Prolonged Service – Without Direct Patient Contact (Tab 14)

Megan Adamson, MD (AAFP), Audrey Chun, MD (AGS), Charles Hamori, MD (ACP), Omar Hussain, MD (ACP), Kevin Kerber, MD (AAN), Steven Krug, MD (AAP), Kano Mayer, MD (NASS), Phillip Rodgers, MD (AAHPM), Karin Swartz, MD (NASS), Edward Tuohy, MD (ACC), Elisabeth Volpert, DNP, APRN (ANA), Thad Waites, MD (ACC) and Richard Wright, MD (ACC)

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 from CMS in the July 2019 Proposed Rule for the 2020 Medicare Physician Payment Schedule. In this 2020 Proposed Rule, CMS also stated that the valuation of CPT codes 99358 and 99359 should be reviewed. In the Final Rule for 2020, CMS noted its belief that the CPT guidelines for 99358 and 99359 needed to be revised for clarity and finalized the proposal that CPT codes 99358-99359 would not be payable in association with office/outpatient Evaluation and Management (E/M) visits.

In January 2020, no specialty societies indicated an interest in surveying these services. In the Final Rule, CMS expressed 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 wanted to address questions and concerns that CMS has in this regard, so these prolonged service codes may be appropriately used in conjunction with the E/M office visit codes in 2021 and beyond, after needed CPT clarification. Therefore, the specialty societies recommended that these services be referred to CPT prior to a resurvey of these services. 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 Service section to remove references to typical times to reflect the new total time definition for office visits. In October 2020, the RUC recommended 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 2023 Medicare Physician Payment Schedule.

In February 2021, the CPT Editorial Panel (1) deleted Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services) subsection including codes 99354-99357; (2) revised the Prolonged Service Without Direct Patient Contact heading and guidelines; (3) revised the Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional

Supervision guidelines; (4) revised the Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service heading and guidelines.

99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

The RUC reviewed the survey results from 61 physicians and other qualified healthcare professionals (QHP) and recommends the 25th percentile work RVU of 1.80 for CPT code 99358. The RUC recommends 50 minutes of intra-service and total time. The RUC noted that this time-based code should be reported by itself for between 30 minutes and 74 minutes of time on a date other than the face-to-face EM service without direct patient contact and noted that the survey median of 50 minutes appropriately falls just under the midpoint of that time range. The RUC noted that, although this is a non-face-to-face service, for a patient to require so much physician or other QHP time on a separate date before and/or after direct patient care, the patient would most typically be complex. This is reflected in 89 percent of the survey respondents indicating that the following complex patient is typical: “An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that past medical records are needed from the patient's prior physicians or other qualified healthcare professionals, and they are reviewed upon arrival.” Although this service is not face-to-face, the specialties noted, and the RUC concurred, that this service has a moderate level of complexity, as it often involves reviewing records that are in disparate formats from the provider's EMR system, clarifying test results and diagnoses, locating records, and understanding and interpreting imaging and diagnostic tests.

The RUC noted that the CPT parentheticals state that this service is not to be reported on the same date of service as codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99483 and 993X0. Also, the CPT introductory language specifically states the following: “If the prolonged service relates to an evaluation and management service that uses total time to select the service on the date of the encounter, the prolonged service without direct patient contact may not be reported. Prolonged service without direct patient contact may only be reported when it occurs on a date other than the date of the evaluation and management service.”

To justify a work RVU of 1.80, the RUC compared the surveyed code to the second key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU= 2.60, 60 minutes total time) and noted that the surveyed code involves 10 minutes less of intra-service time and the work per unit of time of the recommendation would be appropriately less than the face-to-face office visit reference code. The RUC also compared the surveyed code to CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU= 1.92, 48 minutes total time) and noted that although both services involve a similar amount of time, the surveyed code is somewhat less intense to perform. The RUC noted that the work per unit of time of the recommendation would be appropriately less than the face-to-face office visit reference code. The RUC also compared the surveyed code to CPT code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with*

*interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional (work RVU=1.75 minutes, 40 minutes total time) and noted that although the surveyed code involves 10 minutes more total time, a similar value of 1.80 for the surveyed code would be appropriate as the surveyed code is a somewhat less intense service to perform. **The RUC recommends a work RVU of 1.80 for CPT code 99358.***

99359 Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

The RUC reviewed the survey results from 54 physicians and other qualified healthcare professionals (QHP) and recommends the 25th percentile work RVU of 0.75 for CPT code 99359. The RUC recommends 30 minutes of intra-service and total time for this add-on service. The RUC noted that the first unit of this time-based add-on code would be reported along with the base code if the prolonged service is between 75 minutes and 104 minutes and took these reporting rules into account when determining an appropriate relative value for this service. It was noted that this is a relatively very low volume service for an E/M code, with only 7,861 Medicare utilization in 2019. Although this service is not face-to-face, the specialties noted, and the RUC concurred, that this service has a moderate level of complexity as it often involves reviewing records that are in disparate formats from the provider's EMR system, clarifying test results and diagnoses, locating records, and understanding and interpreting imaging and diagnostic tests.

The RUC noted that the CPT parentheticals state that this service is not to be reported on the same date of service as codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99483 and 993X0. Also, the CPT introductory language specifically states the following: "If the prolonged service relates to an evaluation and management service that uses total time to select the service on the date of the encounter, the prolonged service without direct patient contact may not be reported. Prolonged service without direct patient contact may only be reported when it occurs on a date other than the date of the evaluation and management service."

To justify a work RVU of 0.75, the RUC compared the surveyed code to the second key reference code 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)* (work RVU=0.61, intra-service and total time of 20 minutes) and noted that the surveyed code involves 10 more minutes of total time, justifying a higher value. The RUC also compared the surveyed code to CPT code 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU=1.40, intra-service and total time of 30 minutes) and noted that the reference code is a more intense service to perform and that a value of 0.75 for the surveyed code would have appropriate relativity with this reference service. **The RUC recommends a work RVU of 0.75 for CPT code 99359.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expenses and made modifications to remove the equipment input ED021 *Computer, desktop, w-monitor* from codes 99358 and 99359 on

the basis that this is an indirect expense. EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *exam table* were also removed from the recommended inputs since the patient is not present for these services as they are not face to face. **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.

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

Megan Adamson, MD (AAFP), Audrey Chun, MD (AGS), Charles Hamori, MD (ACP), Omar Hussain, MD (CHEST)

In February 2021, the CPT Editorial Panel deleted Prolonged Service with Direct Patient Contact (Except with Office or Other Outpatient Services) subsection including codes 99354-99357, revised CPT code 99417 and created a new prolonged inpatient service code 993X0. In October 2021, the specialty societies surveyed the two prolonged service on the date of an E/M codes (99417, 993X0) but did not obtain the required number of survey responses for code 993X0. The specialty noted, and the RUC concurred, that the January 2022 meeting is still within the current cycle and would not delay recommendations pertinent to the 2023 Medicare Physician Payment Schedule.

The RUC recommends that the prolonged services on the date of an E/M codes be postponed until January 2022 so the specialty societies can obtain the required number of survey responses for CPT codes 99417 and 993X0.

X. CMS Request/Relativity Assessment Identified Codes

Contrast X-Ray of Knee Joint (Tab 16)

Lauren Golding, MD (ACR) and Andy Moriarty, MD (ACR)

CPT code 73580 was first identified via the high-volume growth screen in 2008. The long history of this code is detailed in the Summary of Recommendation (SOR) form. Most recently, the specialty societies noted that the increased growth in volume 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 the new CPT code 27369 *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography* which was valued by the RUC in October 2017. In 2019, CPT code 27370 was deleted and a *CPT Assistant* article for CPT code 27369 was published in August 2019. Utilization of CPT code 73580 subsequently decreased in 2019 concurrent with the deletion of 27370 and clarification of the appropriate use of these codes.

CPT code 73580 describes the work involved with radiologic supervision and interpretation of x-ray images obtained during arthrography of the knee, as well as fluoroscopic guidance for the arthrogram procedure. The RUC noted that there is a separate CPT code 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)* which describes fluoroscopic guidance for an arthrogram performed with CT or MR. However, surveyed code 73580 includes the work of fluoroscopic guidance. The injection for the arthrogram procedure is reported separately for x-ray, CT, and MR arthrography. The RUC noted that CPT code 73580 is typically (91.6%) reported with CPT code 27369 and was careful to avoid duplication of either physician work and/or practice expense inputs in the recommendation for 73580. In October 2020, the RAW had recommended that CPT code 73580 be referred to CPT to be bundled with CPT code 27369. In February 2021, the specialty society notified AMA staff that they would not

be taking these services to CPT to bundle. They noted that the RUC rationale for CPT code 27369 provides additional information, including why these services were not previously bundled. Specifically, CPT found that bundling the injection code into the arthrography base procedure would not be ideal because it would involve edits to over 70 CPT codes.

In March 2021, the Relativity Assessment Workgroup (RAW) noted that code 73580 was never surveyed and remains CMS/Other sourced, while the specialty societies indicated that they would like to see if utilization decreases further when additional data are available. The RAW recommended, and the RUC agreed, that CPT code 73580 be surveyed for the October 2021 RUC meeting and that the effectiveness of the *CPT Assistant* article should be reexamined in two years (October 2023).

In March 2021, the RAW also noted that although CPT code 73580 describes *Radiologic examination, knee, arthrography, radiological supervision and interpretation*, based on Medicare claims data, it is reported by Diagnostic Radiology only 2.3% of the time. The primary providers are Rheumatology, Family Medicine, Orthopedic Surgery and Physical Medicine and Rehabilitation. Prior to the October 2021 RUC meeting, a letter was submitted on behalf of the family medicine, orthopaedic surgeons, physiatry and rheumatology regarding this code. The letter states that that these specialties did not submit interest in surveying, despite being the primary providers of the service per Medicare claims data, as they believe the reporting of this code associated with their specialties is likely due to misreporting and that radiology is the most appropriate specialty to survey this service. CPT code 73580 was identified to be surveyed for the October 2021 RUC meeting, and radiology elected to survey.

Compelling Evidence

The RUC reviewed and agreed that there is compelling evidence to support a change in physician work for CPT code 73580 based on evidence that: (1) incorrect assumptions were made in the previous valuation and (2) physician work has increased due to changes in technique, knowledge/technology, and the patient population. The RUC noted that CPT code 73580 has never been surveyed and is the result of CMS/Other inputs, thus the methodology for valuation is unknown. Further, the CMS/Other time source is inappropriate to compare the current physician time and work to the survey results.

There has been a change in physician work for CPT code 73580 since CMS assigned a value and times based on the patient population and technology in 1995. In 1995, the typical patient underwent an x-ray arthrogram as an initial diagnostic exam following physician exam and knee radiographs. Today, the patient population has changed. CT and MR arthrography is significantly more common and has largely replaced x-ray arthrography for most patients. X-ray arthrography is reserved for more complex patients who have indwelling hardware from prior surgery that would result in artifact on MR or CT. Whereas it used to be commonly performed, code 73580 now represents a rare procedure that is primarily performed for exceptional patients who cannot receive CT or MR arthrography. Fluoroscopic equipment has also advanced in the past 25 years, allowing for analysis of finer detail and more subtle pathology in these patients. **The RUC concurred that there is compelling evidence that the physician work for this service has changed due to flawed methodology in the CMS valuation and a change in the patient population.**

73580 Radiologic examination, knee, arthrography, radiological supervision and interpretation

The RUC reviewed the survey results from 41 radiologists and determined that the survey 25th percentile work RVU of 0.59 appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes of pre-service time, 14 minutes of intra-service time and 5 minutes of post-service time as supported by the survey.

The RUC compared CPT code 73580 to the top key reference code 72265 *Myelography, lumbosacral, radiological supervision and interpretation* (work RVU = 0.83- and 15-minutes intra-service time) which is a clinically similar radiological supervision and interpretation service that compares favorably to the survey code times. The key reference service has nearly identical times, but is more intense, as it involves assessment of the central nervous system as compared to the knee joint. Similarly, survey respondents reported that the surveyed code was “somewhat less” intense overall than the key reference code. The surveyed code has one minute less intra-service time and is less intense and complex than the reference code and is therefore appropriately valued lower. The RUC also compared 73580 to the second highest key reference code 74022 *Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest* (work RVU = 0.32- and 5-minutes intra-service time) and noted that the surveyed code requires more intra-service and total time than the reference code and therefore is appropriately valued higher.

For additional support, the RUC compared CPT code 73580 to MPC codes 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU = 0.54 and 10 minutes intra-service time) and 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60 and 10 minutes intra-service time) and noted that the multi-specialty points of comparison services have less intra-service and total time yet the amount of physician work closely brackets the surveyed code. The RUC concluded that CPT code 73580 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.59 for CPT code 73580.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

3D Rendering with Interpretation and Report (Tab 17)

Melissa Chen, MD (ASNR), Lauren Golding, MD (ACR), Ryan Lee, MD (ASNR) and Andy Moriarity, MD (ACR)

In the Final Rule for the CY 2020 Medicare Physician Fee Schedule, CMS nominated CPT code 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation* as potentially misvalued. The Agency views CPT code 76377 to be part of the same family as CPT code 76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*, which was recently reviewed at the April 2018 RUC meeting. CMS requested that CPT code 76377 also be reviewed to maintain relativity within the code family.

The specialty societies surveyed CPT code 76377, as requested by CMS, yet disagree with the Agency’s rationale for the nomination of the code as potentially misvalued, as they still do not believe that CPT codes 76376 and 76377 are part of the same code family. During discussion of CPT code 76376 in April 2018, it was noted that “CPT code 76377 was not surveyed for the April 2018 RUC meeting with 76376 for several reasons. CPT code 76376 is performed by technologists on the diagnostic workstation for a wide variety of clinical exams with the images subsequently interpreted by the radiologist to answer specific clinical questions at the request of the referring physician. CPT

code 76377 is for technically demanding reconstructions typically performed by the radiologist on an independent workstation. These are much more involved data reconstructions on a few specific types of exams. The patient population undergoing CPT code 76376 is much different than the 76377 code.”

At the October 2021 meeting, the family for CPT codes 76376 and 76377 was questioned again. The specialty societies resolutely maintain that these two services are not a code family. CPT code 76377 involves the creation of 3D reconstructions of the organs of interest using an independent workstation, requiring complex software post processing, such as for surface rendering or tractography. This specialized hardware and software is never utilized when performing the work of 76376. Despite similar descriptors, the societies emphasized that the two codes are different due to the different clinical indications for each code, different patient populations, and fundamental differences in both the equipment needed to perform the work and the type of provider that performs the rendering. The typical patient for 76377 is a patient with a renal cell carcinoma and those patients where the surgeons are considering nephron-sparing surgery. Code 76377 is used for very intricate detailing of the tumor for pre-surgical planning. It is important to isolate the tumor and discern the relationship between the vessels, requiring more time and effort on the physician’s part than for code 76376. It was further noted that the technical and professional resources required for 76376 and 76377 are significantly different. The specialties maintained that the physician work required for these two services is inherently different and not part of the same family.

Compelling Evidence

The specialty societies chose to address compelling evidence, although not required, in order to support their recommendation for maintaining the current value of CPT code 76377 despite decreases in intra-service and immediate post-service time. The argument for compelling evidence was based upon a change in technique and patient population. CPT code 76377 was last reviewed in 2005 when 3D rendering was first becoming a possibility in routine clinical care. Over the intervening years, there have been many changes in both the quality of the source imaging (e.g., increasing use of multiparametric and dynamic MRI, thinner slice CT source images, etc.) and the capabilities of postprocessing software. These changes have allowed for finer anatomical detail and have increased the requirements and expectations of ordering clinicians. Additionally, there has been a significant increase in patients eligible for nephron-sparing surgery for renal cell carcinoma since 2005. With modern treatment options, accurate and detailed 3D rendering is now a more significant component of surgical planning. The RUC reviewed and agreed that there has been a significant increase in imaging technology since the code was initially valued in 2005, including an increase in the number and complexity of software programs that can be used to reformat the types of imaging and an increase in the number and quantity of data obtained from the source imaging. The significant changes in technology (dynamic MRI, multi parametric MRI, and more advanced CT imaging), and creation and review of these images, results in more complexity overall in performing this code. **The RUC concurred that there is compelling evidence that the physician work for this service has changed due to a change in technique.** Although the recommendation does not request an increase in value, compelling evidence was established to justify the decreases in time and establish an increase in intensity and complexity.

76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

The RUC reviewed the survey results from 53 radiologists and neuroradiologists and determined that maintaining the current work RVU of 0.79, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes pre-service evaluation time, 15 minutes intra-service time and 5 minutes post-service time as supported by the

survey. As referenced above, the technology and expectations for performing this service have changed since it was last valued in 2005. As a result, the RUC believes that maintaining work value while slightly lowering total time is appropriate given the increase in intensity. The specialty asserted that the survey respondents accurately identified that this service has seen some increase in work efficiency and time based on improvements in postprocessing workflow but that the intensity and complexity of the work has increased.

The RUC compared CPT code 76377 to the top key reference code 71270 *Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.25, 5 minutes pre-service evaluation time, 18 minutes intra-service time and 4 minutes immediate post-service time) and noted that the surveyed code has slightly less intra-service time and is less intense than the reference code and therefore is appropriately valued lower. The RUC also compared 76377 to the second top key reference code 70450 *Computed tomography, head or brain; without contrast material* (work RVU = 0.85, 4 minutes pre-service evaluation time, 10 minutes intra-service time and 4 minutes immediate post-service time) and noted that the surveyed code has more intra-service time yet is much less intense than the reference code and therefore is appropriately valued lower.

For additional support, the RUC compared CPT code 76377 to MPC codes 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.90, 4 minutes pre-service evaluation time, 15 minutes intra-service time and 3 minutes immediate post-service time) and 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 5 minutes pre-service evaluation time, 15 minutes intra-service time and 6 minutes immediate post-service time) and noted that the multi-specialty points of comparison values have identical intra-service time and are both more intense than the surveyed code, justifying the recommendation. The RUC concluded that the value of CPT code 76377 should be maintained at 0.79 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 0.79 for CPT code 76377.**

Practice Expense

The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that this service has changed based on change in technology and patient population. CPT code 76377 was last reviewed by the RUC in 2005. In the past 16 years, there have been significant changes in both technology and patient population. Specifically, the number and complexity of available post-processing software packages has increased since 2005, requiring more time to reconstruct and review images. The change in patient population is based largely on the typical patient who has a renal cell carcinoma which now, since the code was originally surveyed, can be treated with nephron-sparing surgery; therefore, this code is now used for very intricate detailing of the tumor for pre surgical planning. These changes have resulted in increased times for this service. There have also been changes in RUC methodology with standardization of times for practice expense inputs since the code was last valued. In addition, the current equipment inputs for this code erroneously omit a professional PACS workstation. However, the work of this service includes dictating the report, which is done on a professional PACS workstation and therefore 18 minutes are recommended based on the professional PACS formula. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

XI. Multi-Specialty Points of Comparison Workgroup (Tab 18)

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

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Sunset of MPC Codes Not RUC reviewed Since 2007 (Year of Standardized Pre-Service Time Packages)

The MPC Workgroup continued a discussion from the March 2021 Workgroup meeting as to whether the Workgroup should continue to review MPC codes that have not been RUC-reviewed in the past 15 years. The Workgroup discussed this issue at the March 2021 meeting and concluded that any codes that have not been RUC-reviewed since 2007 would not include standardized pre-service time packages and therefore should be identified for potential replacement on the MPC list.

The Workgroup noted that RUC processes have changed in the past 15 years and that as of 2022, any CPT code that had undergone RUC review in the past 15 years would include standardized pre-service time packages and potentially have been reviewed under Relativity Assessment Workgroup screens, thus providing an additional level of scrutiny in the review processes.

The Workgroup recommended keeping in place the 15-year screen for MPC codes during the Workgroup's annual code review (generally ahead of the January RUC meeting) and ask specialty societies to either justify a code's position on the MPC list or to recommend that the code sunset off the MPC list.

The MPC Workgroup recommends that the following codes should be identified to specialty societies in November 2021 as those not RUC-reviewed in the past 15 years. The specialty society recommendations will be reviewed at the January 2022 MPC meeting.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	0.90	010	2005-08	24,133
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	1.45	010	2005-08	115,439
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	1.84	010	2005-08	48,049
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	1.53	010	2005-08	30,002
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	1.77	010	2005-08	30,312
11443	Excision, other benign lesion including	2.34	010	2005-08	8,316

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm				
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	2.07	010	2005-08	23,703
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	3.11	010	2005-08	25,312
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	2.17	010	2005-08	29,582
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	2.62	010	2005-08	89,442
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	3.42	010	2005-08	32,484
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	9.23	090	2005-08	90,113
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	3.65	000	2006-04	24,066
15003	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	0.80	ZZZ	2006-04	43,311
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or	4.58	000	2006-04	32,464
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	43.28	090	2005-08	3,163
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	39.88	090	2005-08	5,001

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Approved by the RUC January 13, 2022

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	090	2005-08	1,849
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	2006-04	250
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	1.73	000	2006-02	20,612
70355	Orthopantomogram (eg, panoramic x-ray)	0.20	XXX	2005-08	34,300
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	1.99	XXX	2006-04	3,816
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	1.37	XXX	2006-04	40,526
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	XXX	2005-08	5,905,780
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)	2.25	ZZZ	2005-08	560,661

Temporary Removal of CPT Codes Under Current RUC Review

The MPC Workgroup discussed whether MPC codes under current RUC review should be automatically removed from the MPC list until CMS finalizes their valuation. This discussion stemmed from a proposal by the American College of Surgeons (ACS) at the March 2021 Workgroup meeting for the Workgroup to temporarily remove any CPT codes that are under current RUC review. **The Workgroup agreed that moving forward, all codes under current RUC review should be removed from the MPC.**

One current MPC code - **CPT code 77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)** – is under review for the October 2021 RUC meeting and should be removed under this recommendation.

Once it was determined by the Workgroup that AMA staff will remove any codes from the MPC list that are under current RUC review, a discussion ensued regarding reinstatement of such codes. **Once CMS finalizes a valuation for any code that is removed from the MPC for this reason, AMA staff will communicate with the specialty societies to determine whether they wish to place these codes back onto the MPC list during the annual review of MPC codes. If the specialty societies wish to place back on the MPC list, it will be placed on a consent calendar for consideration by the MPC Workgroup.**

The following codes will be considered for the reinstatement process in November 2022.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	9.06	090	2010-10	5,470
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	0.54	ZZZ	2015-10	528,759
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	0.17	XXX	2009-10	301
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	1.92	XXX	2006-02	1,759,562
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	2.61	XXX	2006-02	6,459,408
99223	Initial hospital care, per day, for the	3.86	XXX	2006-02	10,626,847

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.				
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	0.76	XXX	2006-02	6,736,945
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	1.39	XXX	2006-02	44,656,174

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	2.00	XXX	2006-02	24,607,697
99238	Hospital discharge day management; 30 minutes or less	1.28	XXX	2006-02	2,550,501
99239	Hospital discharge day management; more than 30 minutes	1.90	XXX	2006-02	5,189,830
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	0.48	XXX	2018-04	67,730
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	0.93	XXX	2018-04	352,496
99283	Emergency department visit for the	1.60	XXX	2018-04	2,744,710

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.				
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	2.74	XXX	2018-04	5,415,650
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	4.00	XXX	2018-04	11,514,274
99304	Initial nursing facility care, per day, for the evaluation and management of a patient,	1.64	XXX	2007-02	336,776

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.				
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	3.06	XXX	2007-02	1,389,990
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	1.16	XXX	2007-02	11,302,104
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key	1.55	XXX	2007-02	10,009,767

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.				
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	2.35	XXX	2007-02	1,671,664
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.	1.71	XXX	2007-02	100,126
99326	Domiciliary or rest home visit for the evaluation and management of a new patient,	2.63	XXX	2007-02	57,317

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.				
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	3.46	XXX	2007-02	67,147
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.	1.72	XXX	2007-02	1,241,609
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history;	2.46	XXX	2007-02	1,676,057

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.				
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.	3.58	XXX	2007-02	547,337

Removal of a CPT Code from MPC when the Work RVU Determined by CMS is Not Consistent with RUC Recommendation

The MPC Workgroup discussed CPT codes on the MPC list for which CMS did not accept the RUC-recommended work RVU value (there are 34 such codes on the current MPC list). The Workgroup understands that many of these services may be important to specialty societies, with few other services available for the MPC. Many of the services were reviewed years ago and the specialty societies may have accepted the CMS decision. While several MPC Workgroup members believed that codes with RUC approved values would be better comparisons, a decision was made to defer to the specialty societies.

The Workgroup recommended that specialty societies retain the right to recommend the addition to or maintenance on the MPC list of a CPT code for which CMS did not accept the RUC recommended value (i.e., a CMS adjustment should not preclude a code from being on the MPC list). The Workgroup recommended that specialties be asked to review these codes when the next request is distributed in November 2021 and notify the MPC workgroup if they wish to remove any of these services.

The MPC Workgroup recommends specialty society review of the following codes for which CMS did not accept the RUC-recommended work RVU value and notify the Workgroup if any of the following codes should be removed:

Code	Long Descriptor	2021 Work RVU	RUC Rec	Global	2019 Frequency
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.22	1.50	010	368,976
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.01	1.12	000	1,938,307
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	2.70	3.00	000	456,527
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	4.10	4.56	000	88,567
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	7.07	8.00	090	2,079
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	7.42	8.40	090	1,657
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	5.86	6.60	090	1,365
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	7.80	8.00	090	11,733
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	58.79	59.00	090	1,812
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)	2.09	2.32	ZZZ	13,979
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	1.28	1.38	000	71,670
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	12.11	090	38,983
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	9.09	10.05	090	10,329

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Code	Long Descriptor	2021 Work RVU	RUC Rec	Global	2019 Frequency
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	39.88	40.90	090	12,479
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	8.88	9.08	010	3,464
52000	Cystourethroscopy (separate procedure)	1.53	1.75	000	897,375
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2.75	2.80	000	62,618
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	2.82	2.83	000	151,015
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	7.50	7.88	000	11,180
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	4.00	4.50	000	26,625
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	1.01	1.20	ZZZ	101,717
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	6.55	7.73	090	5,906
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are inc	14.56	15.20	090	4,687
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	13.36	14.00	090	1,020
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	25.18	29.07	090	1,030
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11.19	12.37	090	7,841
60500	Parathyroidectomy or exploration of parathyroid(s);	15.60	16.78	090	18,399

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Code	Long Descriptor	2021 Work RVU	RUC Rec	Global	2019 Frequency
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	5.60	6.10	010	8,146
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	5.19	6.05	010	29,921
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	0.26	0.30	XXX	9,755
85097	Bone marrow, smear interpretation	0.94	1.00	XXX	140,727
92273	Electroretinography (ERG), with interpretation and report; full field (ie, fERG, flash ERG, Ganzfeld ERG)	0.69	0.80	XXX	68,699
92567	Tympanometry (impedance testing)	0.20	0.50	XXX	922,916
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	2.00	XXX	1

The Workgroup also discussed six End-Stage Renal Disease (ESRD) codes on the MPC list for which CMS adjusted the work RVU values without RUC review. The Workgroup recommended deferring any MPC list action with respect to these six ESRD codes until the Administrative Subcommittee reviews the codes and determines whether they should be flagged to not be used for RUC comparisons. **At the October 2021 meeting the RUC determined, based on the action of the Administrative Subcommittee, that ESRD codes (90960, 90961, 90962, 90966, 90969 and 90970) will be removed from the MPC list.**

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	6.77	5.18	XXX	2,218,361
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	5.52	4.26	XXX	719,245
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month	3.57	3.15	XXX	213,048

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Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	5.52	4.26	XXX	365,733
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	0.33	0.29	XXX	3,635
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	0.18	0.14	XXX	940,201

MPC List Code Selection Criteria Update for Prospective New Codes to MPC – Consider Requirement of Work RVU Based on RUC Survey (Versus Crosswalk or Other Methodology)

The MPC Workgroup discussed adding the following criterion for codes being added to the MPC list under the MPC list’s “Suggested Criteria”: “Codes should have a work RVU value based on RUC survey results, as opposed to a direct work RVU crosswalk or other methodology.” The Workgroup agreed that as the use of survey results is the preferred methodology, MPC codes should ideally be valued under this methodology. The Workgroup recommended that this criterion should be included under “Suggested Criteria”.

The MPC Workgroup recommends amending the “MPC Code Assessment Criteria & Considerations” as highlighted below:

MPC Code Assessment Criteria & Considerations:

In maintaining the MPC list, the MPC Workgroup should consider the below criteria when assessing the appropriateness of specialty society recommendations. Furthermore, the Workgroup should pay special attention to whether the codes achieve either one of two primary purposes: 1) the recommended codes fill a perceived work RVU gap within the entire MPC list, or 2) the recommended codes fill a perceived work RVU gap within each individual specialty’s current MPC codes.

Absolute Criteria:

- The codes should have current work RVUs that the specialty(s), RUC and CMS accept as valid.
- Any specialty(s) that perform(s) greater than 10% of the total utilization or greater than 10,000 billing instances of the service should have the right to consider the appropriateness of the inclusion of the service on the MPC list. The MPC Workgroup will review that request in consultation with the performing specialty(s), which shall be offered the opportunity to comment, and make a recommendation to the RUC for final determination.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

Suggested Criteria (not Absolute Requirements):

- Codes should represent a spectrum of low to high work RVUs.
- The codes should span the range of global periods for services.

- Codes should be reflective of the entire spectrum of services provided by specialty societies.
- Codes that are frequently performed should be reflected on the MPC list.
- To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties.
- Codes on the MPC list should be understood and familiar to most physicians.
- Codes with utilization of less than 1,000 should not be included on the MPC list without justification by a specialty society.
- Codes should have a work RVU value based on RUC survey results, as opposed to a direct work RVU crosswalk or other methodology.

The RUC approved the Multi-Specialty Points of Comparison Workgroup Report.

XII. Professional Liability Insurance Workgroup (Tab 19)

Doctor Gregory DeMeo, Chair, provided the report of the Professional Liability Insurance (PLI) Workgroup.

Proposed Specialty Overrides for Low Volume Services

The standard process for deriving professional liability insurance (PLI) RVUs uses the most recent year's Medicare claims data to determine a specialty-weighted liability insurance premium as one of the main input into the PLI RVU formula. CMS also performs a similar analysis to determine the specialty mix as part of the process for deriving the indirect practice expense portion of the PE RVUs. On occasion, a few erroneous claims with an incorrect CPT code number are present in the data CMS uses to derive PLI and indirect PE RVUs (meaning for those services the wrong specialty(ies) were used to derive the PE and PLI RVUs for the impacted code). For services with a thousand or more claims, a handful of errant claims would have virtually no impact. However, for CPT codes that have very low volumes in the Medicare population, a few erroneous claims could have a large negative impact. To mitigate this issue, beginning in 2018, CMS first implemented a policy recommendation from the RUC to use single specialty override assignments for the assigned PLI risk premiums and indirect practice expense for very low volume services (those with an average of less than 100 Medicare utilization over the past 3 years). The current list, which includes over 2,000 codes, is available in the Proposed Rule addenda files.

For CY2022, AMA RUC staff performed an analysis to identify all eligible codes and put together a list of potential specialty overrides for each newly eligible service. Following the completion of the analysis and initial review, AMA Staff circulated the list to all RUC participants soliciting specialty society feedback on whether the suggested specialty override would be appropriate for each of the newly eligible service and received robust feedback. The specialty recommendations were integrated into an updated version of the spreadsheet shared with the PLI Workgroup.

The PLI Workgroup reviewed the updated proposed list of low specialty overrides for eligible services. The proposed list included 164 newly added services, reactivation of the specialty override for 327 services already on the list (though that CMS had previously found no longer eligible), and deactivation of the specialty override for 14 services that are no longer eligible. Separately, the Society of Thoracic Surgeons (STS) and American Association for Thoracic Surgery (AATS) had also submitted proposed changes for services that CMS already includes on the override list, though where STS and AATS disagree with the CMS-assigned specialty. 98 out of 104 of these recommendations are for switching the specialty override from Thoracic Surgery to Cardiac Surgery.

Following review of specialty society feedback, the PLI Workgroup revised the initially proposed specialty overrides from AMA staff for a subset of the codes.

The PLI Workgroup approved the proposed list of Expected Specialty Recommendations for Low Volume Codes for CY2022 NPRM Comment (as included in tab 19 of the agenda materials).

Review of Draft RUC Comment Letter Section on PLI

The Professional Liability Insurance (PLI) Workgroup was asked to review and approve the PLI portion of the RUC's draft comment letter on the CMS *Proposed Rule* on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2022. The Workgroup agreed that the draft content prepared by AMA RUC Staff was appropriate and did not have any suggested changes.

New Business

STS and AATS noted that the malpractice adjustment factor for thoracic surgery (6.45) is slightly higher than that for cardiac surgery (6.37) and that having thoracic surgery as slightly higher than cardiac surgery is possible incorrect. The STS has commented on this in several of the rules as well asking CMS for clarification on why the thoracic surgery malpractice risk factor is higher than the cardiac surgery malpractice risk factor. The Workgroup concurred that the relationship is unexpected though requested for the societies to submit data demonstrating that the current malpractice risk factors are incorrect.

The RUC approved the Professional Liability Insurance Workgroup Report.

XIII. Relativity Assessment Workgroup (Tab 20)

Doctor John Proctor, Chair, provided the Relativity Assessment Workgroup report in which they reviewed two action plans.

High Volume Growth (77014)

The Workgroup reviewed high volume growth code 77014. In August 2021, the specialty societies informed the Relativity Assessment Workgroup that in July 2021, CMS released modifications to the Radiation Oncology-Advanced Alternative Payment Model (RO-APM) as part of the 2022 rule making cycle. In the interest of rate setting for the RO Model roll out and early payment stability, maintenance of the components of the RO-APM is viewed as critical. Additionally, the specialty societies indicated that the growth in 77014 is consistent with the standard growth in cancer treatments. As such, the specialty societies requested maintenance of the inputs for CPT Code 77014 and removal from the high-volume growth screen. The Relativity Assessment Workgroup agreed that stability for the RO-APM is important and that the growth of 77014 is appropriate. **The Workgroup recommended maintaining CPT code 77014 and removing it from the current high volume growth screen.**

CMS/Other Source – Medicare Utilization over 20,000 (G0506)

The Workgroup also reviewed CMS/Other Source code G0506 *Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)*. The Workgroup requested that an action plan be reviewed at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or this G code should be surveyed. In January 2021, the RUC recommended to allow changes to the Principal Care Management/Chronic Care Management codes to occur (January 2021 RUC meeting). The specialty societies assessed the NRPM for 2022 (released

July 2021) response from CMS noting that CMS did not delete G0506. Subsequently, the specialty societies submitted an action plan stating that the RUC should request that CMS delete G0506, as it is already reportable by CPT code 99491 *Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.*

The RUC noted that code G0506 is now irrelevant when it relates to office visits as history and physical are no longer requirements for code level selection. The total time on the date of the encounter and the medical decision-making rules address this service. It may still be needed for chronic care management (CCM) assessments, assisted living facilities and home patients. The code will also be unnecessary in 2023 as the E/M changes for the home visit and assisted facilities will be implemented.

The Workgroup agrees with specialty societies' action plan as proposed and requests that CMS delete G0506 for the Final Rule for 2022, as this service may be reported with CPT code 99491.

The RUC approved the Relativity Assessment Workgroup report.

XIV. Practice Expense Subcommittee (Tab 21)

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

Bubble Contrast Supply Item

The PE Subcommittee determined that SD332 *bubble contrast*, an ultrasound-specific contrast agent, should be removed from the supply inputs for CPT codes 76978 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion* and 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)*. This supply item is not necessary because contrast agents are reported separately via temporary Q codes. The contrast agent used for these procedures is separately reported using existing HCPCS Level II supply codes, such as Q9950 *Injection, sulfur hexafluoride lipid microspheres, per ml*. **The PE Subcommittee recommends that the RUC request that CMS remove supply code SD332 bubble contrast from CPT codes 76978 and 76979 and from the direct PE inputs medical supplies listing. The PE Subcommittee also recommends that the AMA staff consider whether the supplies list and submitted spreadsheets can be screened for separately billable items from the HCPCS codes.**

Clinical Staff Pre-Time Package for Major Surgical Procedures (New 000 or Conversion from 090 to 000 day global)

At the April 2021 RUC meeting, the PE Subcommittee presented its report of the Pre-Service Time Global Conversion Workgroup which determined that the current process of handling the codes with conversions in global periods from 90-day to 000- or 010-day on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for these procedures. The RUC agreed with the recommendation that there should be no change in how conversion codes are handled regarding pre-service clinical staff time.

However, the intention of CMS to fully utilize pre-service time packages was demonstrated with the release of the CY 2022 Proposed Rule in July 2021 wherein the Agency clearly relied on pre-service time packages despite RUC recommendations justifying varied pre-times for specific codes. The RUC indicated in its Comment Letter that it would review this issue in October 2021 as part of the Practice Expense Subcommittee agenda. Due to CMS' reliance on packages for pre-service clinical staff times, the surgical specialties submitted a letter to request that the PE Subcommittee re-assess the need to add an additional facility category for major surgical procedures to the 0-day and 10-day global chart of pre-service clinical staff times.

The PE Subcommittee discussed the request of the surgical specialties and the recent Workgroup report and determined that a new PE Workgroup should be created to determine whether the addition of another pre-service time package is warranted. The Chair indicated that the composition of the workgroup will consist of some former members but mostly new members to try to develop a novel, innovative yet comprehensive solution to this recurring issue.

The RUC approved the Practice Expense Subcommittee Report.

XV. Research Subcommittee Workgroup (Tab 22)

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

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

The Research Subcommittee report from the May 24th conference call included in Tab 22 of the October 2021 agenda materials was approved without modification.

Discussion – Intra-Work Per Unit Time (IWPUT) Comparisons

At the April 2019 RUC meeting, the RUC recommended for the full increase of work and physician time for office visits to be incorporated into the surgical global periods for each CPT code with bundled post-operative office visits. CMS decided to not accept this RUC recommendation, resulting in bundled post-operative office visits in the surgical global period having divergent lower values relative to separately reported office visits. Due to CMS' decision, the RUC Database and the Intra-service Work Per Unit of Time (IWPUT) calculator spreadsheet continue to use the 2020 office visit work values as inputs to the IWPUT formula.

At the January 2021 RUC meeting, a RUC member requested that the Research Subcommittee review the impact to IWPUT comparisons based on CMS' decision. The Subcommittee had a robust discussion related to IWPUT during the October 2021 meeting. The pre-service 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. These intensities are widely divergent from the work per unit time for separately reported office visit services (0.04).

The Subcommittee reiterated its concern, previously discussed at its meeting in March, that the IWPUT formula has lost some validity and utility. The Subcommittee noted that the IWPUT metric still has strong utility within a code family and some utility when comparing recently reviewed services with the same global period and similar lengths of physician time. However, it has lost a lot of its relevance with respect to comparing services with different global periods, large differences in time and/or that were reviewed many years apart from each other.

The Research Subcommittee recommends for IWPUT to continue to be used internally in the RUC summary spreadsheets and in the RUC Database.

Work Per Unit Time (WPUT) Analysis

During the *New Business* discussion at the April 2021 RUC meeting, a RUC member requested that staff perform an analysis for the Research Subcommittee to have a general discussion about Work Per Unit Time (WPUT). This analysis, which summarizes WPUT by global period and code ranges, is included in the Research Subcommittee agenda materials (file *03b WPUT Analysis*).

The Chair noted that there is no specific action that is being requested of the Subcommittee and that this analysis was provided to spur a general discussion. It was also noted that, in 2020, WPUT was added to the RUC summary spreadsheet. Several Subcommittee members noted that this metric has been a helpful addition and has some overlapping utility with the IWPUT data point. It was noted that these represent averages and mid-points, and individual services will have variance depending on their work intensity. The Subcommittee noted that the median and percentiles datapoints were of the most interest. The Research Subcommittee had decided that no further action was needed, as the WPUT metric is already included in the RUC summary spreadsheet. The Research Subcommittee and the RUC will continue to monitor the use and validity of the WPUT metric.

Review of Proposed Updated Targeted Sample Guidelines

At the March 2021 Subcommittee meeting, AMA staff suggested an alternative where societies could use targeted survey sample methodology provided they comply with a list of specific requirements. At that meeting, the Research Subcommittee approved that certain targeted survey sample requests would no longer need to be reviewed and approved by the Subcommittee provided they meet certain criteria ensuring the vendor provides its complete list and the survey population also includes a simple random sample or a random sample of applicable subset of each society's membership. AMA staff, the Chair and the Vice Chair worked together to draft proposed text for the Subcommittee's consideration during this meeting. It was noted that targeted sample requests that involve vendor lists are only done currently for services that involve new technology or very low volume.

The Research Subcommittee approved the following changes to section 3 of the Research Subcommittee Guidelines and Requirements document:

Survey Sample Methodology:

- a. **Review Requirements:** The RUC expects ACs to use a random survey to develop relative value recommendations and should disclose the process used and the population sampled in the rationale section of Summary of Recommendation (SOR) form. Use of either a *Simple Random Sample* ([Addendum A-I](#)) or a *Random Sample of Applicable Subset(s)* ([Addendum A-II](#)) for a RUC survey does not require Research Subcommittee approval. **In addition, use of a vendor-provided list of all trained US providers known to the vendor does not require Research Subcommittee approval, provided that the vendor signs the RUC vendor attestation statement prior to the launch of the survey and the survey sample also includes either a simple random sample or a random sample of applicable subset(s) of each participating society's membership.**

If a specialty intends to use any other survey sample method, defined as a *Targeted Sample* ([Addendum A-III](#)), they must request review and approval by the Research Subcommittee prior to surveying the code(s). Also, if you plan to request data from a vendor for direct practice expense information, you must also submit the request in advance to the Research Subcommittee.

- b. **Submission Requirements:** Submission must define the source of any proposed targeted sample and should explicitly state whether the AC intends to use only a targeted survey sample, both targeted and random samples or a survey which includes all names on the targeted list. Inclusion of a short-written rationale with your Research Subcommittee request is strongly recommended.
- c. **Requirements pertaining to your RUC Submission and Presentation:**
 - i. If a Research Subcommittee approved “targeted survey” consists of contact information provided from a company/vendor, the specialty society must have the company/vendor sign the [RUC Company/Vendor Attestation Statement](#) stating no further communication regarding the survey or valuation occurred.
 - ii. If ~~your the Research Subcommittee approves of~~ survey sample methodology ~~which~~ includes both a targeted sample and a random sample, the summary data would need to have targeted and random samples presented separately and together to the RUC. The summary data must be listed both separately and together in the summary excel spreadsheet and the SOR rationale section must summarize the separated and aggregated survey data.

Addendum A: Terms and Definitions

- I. **Simple Random Sample:** A randomly selected subset of a society’s general US membership with available email addresses, excluding RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees. Each individual in the subset is chosen randomly, such that each individual has the same probability of being chosen. The use of this sampling methodology does not require approval from the Research Subcommittee.
- II. **Random Sample of Applicable Subset(s):** Sampling from one or more subsets of a society’s US membership with available email addresses based on certain subset characteristics, excluding RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees. The goal of this methodology is to distribute surveys to those members of a society that are most likely to be familiar with or have experience performing the service under review. A random sample from each applicable subset, where each individual in the subset has the same probability of being chosen, should be taken. Whenever using multiple subsets, the Advisory Committee should endeavor to make the proportion of each subset analogous to the estimated demographics of the providers performing the service under review.

Subset characteristics of the specialty society that do not require Research Subcommittee approval are:

- Subspecialty certification or designation
- Member has indicated experience with a certain modality, body region or diagnoses
- Inclusion in an established specialty society member section

When using this sampling methodology, clearly explain how the sample was derived on the RUC Summary of Recommendations form under *Description of Sample*.

- III) **Targeted Sample:** Any sampling method which falls outside the definition of a Simple Random Sample or a Random Sample of Applicable Subset. The goal of this methodology is to distribute surveys to physicians or other qualified healthcare providers ~~those members of a society~~ that are most likely to be familiar with or have experience performing the service under review. Any list provided by industry is classified as a targeted sample. RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees should be excluded. All targeted samples must be approved by the Research Subcommittee. When using this sampling methodology, clearly explain how the sample was derived on the RUC Summary of Recommendations form under *Description of Sample*.

Pre-time Packages for Pediatric Major Surgical Services

During *New Business* at the April 2021 RUC meeting, a RUC member requested that the Research Subcommittee review whether it would be appropriate to create pre-service time packages for pediatric major surgical procedures. AMA staff had noted that the relevant specialty societies performing these services should share recommendations with the Research Subcommittee.

The American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) submitted a proposal for additional pre- and post-service packages specifically for complex congenital cardiac procedures. The request is included in the Research Subcommittee agenda materials.

The specialty presenter gave an overview of the request from ACC and SCAI to recommend a standard 10 additional minutes for pre-service evaluation, 1 additional minute for scrub/dress/wait, 3 additional minutes for positioning and 28 additional minutes for immediate post-service time for complex congenital cardiac procedures. They noted that the existing standard pre- and post-service packages do not accurately align to the work performed in a children's hospital, particularly for the patient with congenital heart disease in the cardiac catheterization laboratory or cardiac surgical suite.

The Research Subcommittee questioned whether the proposed time packages would also cover relatively less complicated procedures or also be applied to relatively older children. Several Subcommittee members noted that they did not think the current time packages act as a barrier, noting that after being discussed, the RUC recommended physician times for the cardiac catheterization and congenital coarctation code families had RUC-recommended times that well exceeded the standard time packages and largely aligned with the societies' proposal. Also, several Subcommittee members noted there are many other groups of major surgical procedures that have pre- and post-service work that is also not captured in the standard packages. **The Research Subcommittee agreed that creating new time packages would not be needed at this time for complex congenital cardiac procedures. The Research Subcommittee does not support the creation of specific complex congenital cardiac time packages. The Research Subcommittee recommends maintaining the current method for specialty societies to advocate for more pre-service and post-service time over the standard pre-service and post-service packages when applicable.**

A Subcommittee member also suggested for the societies to consider maintaining their own internal standards linked to precedent for services that were recently RUC reviewed. The societies could cite these precedents when presenting new sets of codes to the RUC as support.

Discussion – 23-hour Stay CMS Policy and ½ Day Discharge Visits (*referred from April 2021 RUC New Business*)

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Approved by the RUC January 13, 2022

At the April 2021 RUC meeting, the American Academy of Orthopaedic Surgeons (AAOS) submitted a memo to the RUC expressing concerns about the 23-hour stay and half-day discharge policies and their implementation. This request is included in the Research Subcommittee Agenda Materials (*05b Request from AAOS - 23-hr stay policy*).

CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (eg 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. Prior to the CY2011 Final Rule, the RUC has used 0.5 x 99238 as a proxy for same-day outpatient discharge. Though in the CY2011 Final Rule, CMS expanded the ½ day discharge proxy to all outpatient services, including if the patient stays overnight though less than 24 hours — the RUC has also implemented this change following the release of the CY2011 Final Rule.

The Research Subcommittee unanimously agreed that applying the ½ Day Discharge policy to services that have an overnight stay less than 24 hours is flawed and that CMS should modify the policy to only apply the ½ day discharge proxy to services that typically involve a same-day discharge. The Subcommittee noted that, if these services were 000-day global where the patient stayed overnight and was discharged the next day, then a full discharge visit could be reported on the next day — therefore, it is inappropriate to use a ½ day discharge for any services that typically involve an overnight stay.

After briefly discussing whether the Research Subcommittee should both recommend for the RUC and the AMA to advocate for CMS to change its policies and for the RUC to change its rules for these services, the Subcommittee decided it would be best for CMS to first agree to the change prior to the RUC handling these services differently.

The Research Subcommittee recommends for the RUC Chair and the AMA to meet to advocate for CMS to change its policy for discharge day visits in the surgical global period, where the ½ day discharge proxy would only be applicable to services that typically involve a same-day discharge. Similarly, the Research Subcommittee recommends for the RUC Chair and the AMA to meet to advocate for CMS to eliminate its 23-hour stay policy of allocating the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of an outpatient procedure. The Research Subcommittee also recommends for an update on this meeting to be provided to the RUC after it takes place.

Discussion – Review of Services Undergoing Global Period Change

At the October 2020 RUC meeting, a RUC member requested policies to be developed regarding how neutral evaluation of codes undergoing a change in global period should be best accomplished and broadly representative. Currently, there is no formal transition underway, global period changes have occurred 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. The RUC referred this issue to the Research Subcommittee to discuss the process for reviewing services with a proposed global period change, and whether any new policies should be developed.

There were three code families that had codes with global period changes from either 090-day or 010-day to 000-day during the CPT 2022 cycle, and one code family thus far during the CPT 2023 cycle. The Vice Chair noted the concern that it is unclear when compelling evidence should be required for code families that are undergoing global period conversions. Other Subcommittee members expressed

concern that since these services were valued using magnitude estimation that engaging in straight reverse building block methodology would not be appropriate. The Vice Chair concurred that straight reverse building block would not be a viable pathway. A Subcommittee member offered that perhaps a process could be first tested with 010-day global services as they would be less challenging to value than 090-day global services. Another Subcommittee member offered a separate idea regarding a process to determine compelling evidence for these services, that would not be a straight reverse building block. They suggested that presenting societies could also make a recommendation as to what they anticipate to be the typical number and level of separately reported post-operative visits — then the RUC could use those projected separately reported visits as part of its budget neutrality calculation to determine whether compelling evidence is required.

The Vice Chair suggested that a few questions could be circulated electronically to the Research Subcommittee for each member to provide written feedback. This written feedback could be summarized and reviewed at the Subcommittee's next meeting. The Subcommittee concurred that this exercise would be beneficial. The Subcommittee agreed to continue this discussion at its next meeting coinciding with the January 2022 RUC meeting.

The RUC approved the Research Subcommittee Report.

XVI. Administrative Subcommittee (Tab 23)

Doctor Margie Andreae, Chair, presented the three issues which the Administrative Subcommittee reviewed.

CMS Increased the RVW for a Group of Codes independent of a RUC Review (2021)

For CY 2021, CMS proposed and finalized increases for services they stated were analogous to the E/M office visit codes (99202-99215) increased for 2021. The list of codes CMS increased varied widely; some of these services had been previously crosswalked to an E/M office visit, used E/M office visits as a building block, included an E/M office visit as part of the service, or the service was compared to an E/M office visit as a reference point.

In September 2021, the Subcommittee stated concern that the 2021 CMS valuation of these services was not based on standard RUC process – thus a survey with magnitude estimation by the physicians who perform these services, a RUC review and recommendation relative to other services, nor a CMS review and acceptance or refinement was used to establish a relative value. The Subcommittee noted that because the values for these codes did not follow the standard RUC/CMS process, using these codes as comparators or crosswalks in the RUC valuation process would disrupt the integrity of the relativity of services in the database. Basing the value of services in the Medicare Payment Schedule on services that were not established following RUC process appropriately defies the purpose of the RUC – The AMA/Specialty Society *Relative Value Scale Update Committee*.

The Subcommittee acknowledges that the RUC accepts the CMS valuation for services as the current valuation; however, the RUC should not use specific services for comparison that the RUC believes were valued outside of RUC processes, including CMS altering values independent of a RUC recommendation.

The Administrative Subcommittee recommends the RUC flag these 44 services as “Do not use to validate work” in the RUC database. See list of 43 codes below. The Subcommittee noted that nine of these services (90960, 90961, 90962, 90966, 90969, 90970, 99283, 99284, 99285) are currently on the MPC list, therefore, will subsequently be removed by the MPC Workgroup since they are flagged as “Do not use to validate work”.

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The RUC noted that it reviewed CPT codes 99283, 99284, 99285 and 99483 in April 2021 for CPT 2023. These codes should be flagged as “Do not use for validation of physician work” until 2023 after CMS makes its final determination based on the most recent RUC review. However, these four codes do not need to be on the level of interest since they were recently surveyed.

90791	90956	90963	92521	97164	99285	G0438
90792	90957	90964	92522	97165	99483	G0439
90832	90958	90965	92523	97166	99492	
90834	90959	90966	92524	97167	99493	
90837	90960	90968	97161	97168	99495	
90951	90961	90969	97162	99283	99496	
90954	90962	90970	97163	99284	G0402	

Historical Information on Current Work RVU and RUC Reviewed Codes

In April 2021, a RUC member requested that AMA Staff conduct an environmental scan and provide historical information to the Administrative Subcommittee regarding the rules regarding determining work neutrality, compelling evidence and which codes are considered RUC reviewed, as well as provide information about codes that CMS did not accept RUC recommendations.

AMA staff provided information on its policies that the current value is the CMS value, work neutrality, compelling evidence, RUC review date information and physician time source information. When reviewing the compelling evidence historical information, a Subcommittee member noted that there was more specific information regarding what the RUC considers flawed mechanisms or methodology, and the Subcommittee should review again to consider adding more information to its process document. **The Administrative Subcommittee will review the compelling evidence standards and consider specifying standards such as: If a specialty society is presenting a code that was most recently finalized by CMS with a lower work RVU than the previous RUC recommended value, the specialty society may present compelling evidence that that service was based on “flawed methodology” and outline the incorrect methodology (e.g., low survey data point or no specific crosswalk or rationale provided) at a future meeting.**

CMS Final Value Not Consistent with RUC Value

RUC Flags

AMA Staff identified 706 services in which the RUC recommended work RVU was not accepted by CMS.

- Of these services, 385 are already flagged as “CMS Did Not Accept the RUC or HCPAC Recommendation”
- 26 of these services are flagged as “Do Not Use for Validation of Physician Work”
- The remaining 295 do not have any flag notifications
 - Of those that do not have a flag notification, 250 or 85% have 2019e Medicare Utilization under 30,000.
 - All 295 codes that do not have a flag notification were reviewed more than 10 years ago (1992-2011).

Of note, 9% or 680 of the 7,600 codes with a work RVU are based on altered RUC recommendations. A Subcommittee member suggested that the RUC’s compelling evidence standards be revised to specifically state that codes in this category (CMS adjusted RUC recommendations) are categorized

as flawed methodology. This is the intent of the flawed methodology rationale; however, the Administrative Subcommittee will consider clarifying language at a future meeting.

The Administrative Subcommittee agreed that any code where CMS did not accept the RUC recommendation should be flagged as “CMS Did Not Accept the RUC or HCPAC Recommendation” to easily identify this feature of these codes in the database. The Subcommittee acknowledged that the RUC may still use these “CMS did not accept the RUC recommendation” flagged services as references or crosswalks if the specialty societies agree with the current CMS value. However, these flags alert RUC Members and Advisors immediately and allow further discussion on the specialty’s acceptance of the current value before relying heavily on an inappropriate code for valuation. **The Administrative Subcommittee recommends flagging all services since 1992, in which CMS did not accept a RUC recommendation with “CMS Did Not Accept the RUC (or HCPAC when appropriate) Recommendation”.**

The RUC accepted this report as amended. The full Administrative Subcommittee report is attached to these minutes.

XVII. SARS-CoV-2-IA-Boosters, Pfizer Tris-Sucrose, Pfizer Age 5-11 (Tab 24)

Megan Adamson, MD (AAFP), Suzanne Berman, MD (AAP), Charles J. Hamori, MD (ACP), Jon Hathaway, MD, PhD (ACOG), Steven Krug, MD (AAP) and Korinne Van Keuren, DNP, APRN (ANA)

On November 5, 2020, the CPT Editorial Panel created four codes to describe immunization administration (IA) by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. CPT codes 0001A and 0002A are used to report the first and second dose administration of the Pfizer-BioNTech COVID-19 vaccine (ie 30 mcg/0.3mL dosage, diluent reconstituted). CPT codes 0011A and 0012A are used to report the first and second dose administration of the Moderna COVID-19 vaccine (ie 100 mcg/0.5mL dosage).

On December 14, 2020, the CPT Editorial Panel created two codes to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. Codes 0021A and 0022A are used to report the first and second dose administration of the AstraZeneca vaccine.

On January 14, 2021, the CPT Editorial Panel created one new code to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine. Code 0031A is used to report the administration of the Janssen vaccine, which only requires a single dose.

On April 5, 2021, the CPT Editorial Panel created two codes to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. Codes 0041A and 0042A are used to report the administration of the first and second dose of the Novavax vaccine.

On July 30, 2021, the CPT Editorial Panel created new code 0003A to describe the immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine for the Pfizer-BioNTech third dose, for specific populations such as immunocompromised individuals. Subsequently on August 16, 2021, the CPT Editorial Panel created new code 0013A to describe the immunization administration injection for COVID-19 vaccine for the Moderna third dose, for specific populations such as immunocompromised individuals.

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On September 3, 2021, the CPT Editorial Panel created six new codes to describe the immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. CPT codes 0051A, 0052A and 0053A are used to report the first, second and third dose for the Pfizer-BioNTech tris-sucrose formulation, which does not require the ultra-cold freezer. CPT codes 0004A and 0054A are used to report immunization administration of the booster doses of the Pfizer-BioNTech for both formulations and CPT code 0064A is used to report the immunization administration of the Moderna booster dose.

On September 30, 2021, the CPT Editorial Panel created two new codes to describe the immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine for the pediatric population, ages 5-11. CPT codes 0071A and 0072A are used to report the first and second dose administration of the Pfizer-BioNTech COVID-19 vaccine tris-sucrose formulation for children ages 5-11 (i.e., 10 mcg/0.2 mL dosage, diluent reconstituted).

These CPT codes, developed based on extensive collaboration with CMS and the Centers for Disease Control and Prevention (CDC), are unique for each of the six coronavirus vaccines as well as administration codes unique to each corresponding vaccine and dose. The new CPT codes clinically distinguish each COVID-19 vaccine for better tracking, reporting, and analysis that support data-driven planning and allocation. In addition, CPT Appendix Q was created to facilitate an easy guide for proper reporting of all SARS-CoV-2 vaccine CPT codes.

Pfizer-BioNTech and Moderna SARS-CoV-2-Immunization Administration-Boosters, Pfizer Tris-Sucrose, Pfizer Tris-Sucrose Age 5-11

The RUC reviewed the specialty society recommendations and agreed that 0004A (Pfizer booster), 0051A-0053A (Pfizer tris-sucrose), 0054A (Pfizer tris-sucrose booster), 0064A (Moderna booster) and 0071A and 0072A (Pfizer tris-sucrose, age 5-11, first and second doses) should be valued the same as the previous first, second and third doses of all other COVID-19 immunization administration codes with a work RVU of 0.20. For additional support, the RUC referenced codes 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20 and 7 minutes total time), 99188 *Application of topical fluoride varnish by a physician or other qualified health care professional* (work RVU = 0.20 and 9 minutes total time) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 9 minutes total time).

In the case of some COVID-19 vaccines requiring booster doses, the total physician work resources required for the booster dose should be equivalent to those required for the first dose to account for the possibility that a patient may not return to the same physician or even the same physician group for the booster dose administration. Valuation must account for any necessary physician work to confirm the details of a patient's first and second doses. The specialty societies indicated, and the RUC agreed, that all doses and formulations require 7 minutes of physician time. Clinical experience indicates that the physician involvement required to address questions regarding adverse side effects are the same for all doses. Therefore, the RUC agreed that there is no difference in physician work between the administration of any booster doses or pediatric doses nor is there any difference in physician work or time to administer a single dose of the Pfizer-BioNTech (either formulation), Moderna, AstraZeneca, Janssen or Novavax immunizations. The RUC recommends the booster doses Pfizer-BioNTech and Moderna COVID-19 IA and Pfizer-BioNTech tris-sucrose formula for adults and children ages 5-11 COVID-19 IA codes be valued the same as the first, second and third doses of the previous established COVID-19 immunization administration codes (0001A, 0002A, 0003A,

0011A, 0011A, 0012A, 0013A, 0021A, 0022A, 0031A, 0041A and 0042A). **The RUC recommends a work RVU of 0.20 and intra-service time of 7 minutes for CPT codes 0004A, 0051A, 0052A, 0053A, 0054A, 0064A, 0071A and 0072A.**

Practice Expense

The Practice Expense (PE) Subcommittee thoroughly and extensively discussed the practice expense inputs involved with the COVID-19 immunization administration codes in the physician office setting in its December 2020 review of the first and second dose of the Pfizer-BioNTech and Moderna IA codes and determined the same direct inputs apply to the Pfizer-BioNTech and Moderna boosters and Pfizer-BioNTech tris-sucrose formulation COVID 19 immunization administration. The Subcommittee compared the direct PE inputs for the new IA codes with former CPT code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]* and determined that the clinical staff times approved for code 90470 during the 2009 pandemic were appropriate. The inputs mirror the clinical staff times that had been in place for CPT code 90470. The Subcommittee also determined that new CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* would be utilized with these codes and confirmed that there is no overlap in clinical staff times with what is already included in CPT code 99072. **The RUC strongly recommends that CMS approve payment for CPT code 99072 during the Public Health Emergency (PHE).**

The specialty societies emphasized that though the clinical staff activities may be like other vaccination codes, the typical amount of clinical staff time for COVID-19 immunization administration is higher due to the requirements inherent in a public health emergency and due to these services not being typically reported with an evaluation and management service during a PHE. There was significant discussion regarding the considerable documentation requirements that accompany these COVID-19 immunization administration codes. There was agreement that 2 minutes was appropriate for the first dose of the vaccines to identify and contact appropriate patients and schedule immunization. The PE Subcommittee agreed that any third doses and boosters will mirror the first dose for this clinical activity. Since the third dose and boosters of the Pfizer and Moderna COVID-19 vaccine will initially be offered only for certain high risk patients, identification of this patient subset will require selecting high risk patients who have already received the first two doses of the Pfizer or Moderna vaccines – and stratifying them not only from lower risk patients who have already received the first two doses of the Pfizer or Moderna vaccine, but also from patients who have not been vaccinated at all. Therefore, 2 minutes is appropriate for CA005 *Complete pre-procedure phone calls and prescription* to identify and contact appropriate patients and schedule the immunization for the first, third or booster dose of the COVID-19 vaccine.

For pediatric age 5-11 COVID-19 IA codes 0071A and 0072A, 1 additional minute, totaling 3 minutes, was added for CA013 *Prepare room, equipment and supplies* to allow for clinical staff to reconstitute the vaccine for pediatric doses.

The recommendation for CA033 *Perform regulatory mandated quality assurance activity (service period)* remained as L026A *Medical/Technical Assistant* for this type of registry. The first dose of all COVID-19 IA is 7 minutes (0001A, 0011A, 0021A, 0031A, 0041A, 0051A, 0071A). However, 2 minutes less, or 5 minutes total for CA033 are required for the second, third and booster doses for all COVID-19 IA codes (0002A, 0003A, 0004A, 0012A, 0013A, 0022A, 0042A, 0052A, 0053A, 0054A, 0064A, 0072A) since the patient record creation and demographic entry has already been established.

Three minutes of clinical staff time was allotted for CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)* with L037D RN/LPN/MTA, recognizing that more than baseline medical knowledge is required for this activity. This is the same for all COVID-19 IA vaccines and doses. The CDC recommends 15 minutes of monitoring the patient following the administration of each dose for all COVID-19 vaccines. The PE Subcommittee agreed that the standard of 1 minute of clinical staff time to every 4 minutes of patient monitoring is appropriate, leading to 4 minutes for CA022 *Monitor patient following procedure/service, multitasking 1:4*. A follow-up phone call from the patient to the practice to discuss symptoms or address questions was accepted as typical, 3 minutes CA037 *Conduct patient communications*.

The PE Subcommittee extensively discussed the supply and equipment inputs associated with the initial Pfizer, Moderna, AstraZeneca, Janssen and Novavax immunization administration codes. The same supplies are recommended for all COVID-19 IA codes including the previous adjustment, which includes 3 sheets of SK057 *paper, laser printing (each sheet)*. The typical CDC Vaccine Information Statement (VIS) is two pages (i.e., one sheet of laser paper, printed double sided). However, the emergency use authorization (EUA) for the Pfizer COVID VIS is 6 pages, the Moderna COVID VIS is 5 pages and the Janssen COVID VIS is 6 pages. It is anticipated that the Novavax COVID VIS (and future COVID VIS) will follow suit. **Therefore, the Practice Subcommittee recommends SK057 accordingly (i.e., 3 sheets of laser paper, printed double sided) for all COVID IA codes (0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0021A, 0022A, 0031A, 0041A, 0042A, 0051A, 0052A 0053A, 0054A, 0064A, 0071A and 0072A).** The remaining supplies recommended are: SG021 *bandage, strip 0.75in x 3in (Bandaid)* and SB022 *gloves, non-sterile* and exclude any COVID-19 cleaning supplies including additional quantities of hand sanitizer and disinfecting wipes/sprays/cleansers as these are included in CPT code 99072. The PE Subcommittee excluded any supplies that are included in the ancillary supply kit supplied by the Federal Government at no cost to enrolled COVID-19 vaccine providers.

The PE Subcommittee recommended new equipment item *refrigerator, vaccine medical grade, w-data logger snl glass door* for all COVID-19 immunization administration codes and new equipment item *freezer, under counter, ultra-cold 3.7 cu ft.* is recommended for the Pfizer BioNTech immunization administration codes (0001A, 0002A, 0003A and 0004A). It was noted that CPT codes 0051A, 0052A and 0053A for the first, second and third dose for the Pfizer-BioNTech tris-sucrose formulation, do not require the ultra-cold freezer. In 2019, there was significant discussion about the existing equipment ED043 *refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates* and whether it was a direct or indirect expense. ED043 is the monitoring system and was retained as a direct expense in accordance with the spreadsheet. The medication-grade refrigerator is used solely to store highly expensive and fragile biologics for use at the time they are needed. Although the medications are stored for longer than the length of the service, it would be extremely difficult to determine typical length of storage as this varies across local sites. The RUC and CMS have a precedent of including refrigerators in direct expense costs and using the total clinical staff time for the equipment minutes, as was done for vaccination codes, including codes 90471, 90472, 90473, and 90474, where the equipment time for the refrigerator is equal to the total clinical staff time. The RUC recommends that the same refrigerators and monitor would be typical medical equipment for the all COVID-19 immunization administration codes. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Services

The RUC recommends that all COVID Immunization Administration codes (0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0021A, 0022A, 0031A, 0041A, 0042A, 0051A, 0052A 0053A, 0054A, 0064A, 0071A and 0072A) be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Modifier -51 Exempt

The RUC acknowledges that vaccines and immunizations are inherently precluded from the modifier -51 application and note that the revisions to the CPT guidelines are already in place, which include COVID immunizations.

XVIII. Other Business (Tab 25)

A RUC member requested that the **Research Subcommittee** review when it is appropriate to utilize survey data from the specialty or health profession that performs the dominant amount of the service versus using all survey data.

Two RUC members requested that the **Research Subcommittee** review the intensity questions on the survey and previous data from surveys to determine if any improvements may be made to this section of the survey.

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

A RUC member requested that the RUC Relativity Assessment Workgroup consider a new screen that is specific to codes where CMS increases or decreases current work RVUs without identifying the codes as potentially misvalued and/or without requesting review of the codes through the RUC survey process. Specifically, the RUC member requested the RUC first address codes with increases consistent with E/M office visit increases where the RUC and CMS time/visit database does not include E/M visits. CMS justification for increasing these codes was that the codes may have been valued in relation to E/M office visit codes and because the E/M office visits were increased, these CMS identified codes should also have an incremental increase. The RUC member indicated that most of the RUC values for these codes were based on magnitude estimation and not a direct crosswalk to an E/M service. Further, if the specialties or CMS believed the value for these codes was potentially misvalued, then they should have been resurveyed to justify a new value based on magnitude estimation or crosswalk. The RUC member suggested the screen be called "Codes revalued independently by CMS as including inherent E/M work that do not include E/M codes in the time/visit data base" and that the codes be considered potentially misvalued. **Instead of referral, the RUC decided to immediately place all of these codes on a Level of Interest (LOI) for review in the calendar year 2022. The LOI process was conducted immediately after the RUC meeting. Specialties only agreed to survey the Transitional Care Management (TCM) codes for the April 2022 RUC meeting. All others agreed that the flag “Do Not Use to Validate for Physician Work” should remain in the RUC database for the remaining codes in this category.**

The RUC adjourned at 4:35 p.m. CT on Saturday, October 9, 2021.

Workgroup Members Present: Bradley Marple, MD (Chair), Jim Clark, MD (Vice Chair), Amr Abouleish, MD, Jennifer Aloff, MD, Margie Andreae, MD, Charles Fitzpatrick, OD, Stephen Gillaspay, PhD, Gregory Harris, MD, Michael R Kuettel, MD, PhD, Timothy Laing, MD, Howard P. Levy MD, PhD, John Proctor, MD, M. Eugene Sherman, MD, Norm D. Smith, MD

1. Sunset of MPC Codes Not RUC reviewed Since 2007 (Year of Standardized Pre-Service Time Packages)

The MPC Workgroup continued a discussion from the March 2021 Workgroup meeting as to whether the Workgroup should continue to review MPC codes that have not been RUC-reviewed in the past 15 years. The Workgroup discussed this issue at the March 2021 meeting and concluded that any codes that have not been RUC-reviewed since 2007 would not include standardized pre-service time packages and therefore should be identified for potential replacement on the MPC list.

The Workgroup noted that RUC processes have changed in the past 15 years and that as of 2022, any CPT code that had undergone RUC review in the past 15 years would include standardized pre-service time packages and potentially have been reviewed under Relativity Assessment Workgroup screens, thus providing an additional level of scrutiny in the review processes.

The Workgroup recommended keeping in place the 15-year screen for MPC codes during the Workgroup's annual code review (generally ahead of the January RUC meeting) and ask specialty societies to either justify a code's position on the MPC list or to recommend that the code sunset off the MPC list.

The MPC Workgroup recommends that the following codes should be identified to specialty societies in November 2021 as those not RUC-reviewed in the past 15 years. The specialty society recommendations will be reviewed at the January 2022 MPC meeting.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	0.90	010	2005-08	24,133
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	1.45	010	2005-08	115,439
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	1.84	010	2005-08	48,049

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	1.53	010	2005-08	30,002
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	1.77	010	2005-08	30,312
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	2.34	010	2005-08	8,316
11601	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	2.07	010	2005-08	23,703
11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	3.11	010	2005-08	25,312
11641	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	2.17	010	2005-08	29,582
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	2.62	010	2005-08	89,442
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	3.42	010	2005-08	32,484
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	9.23	090	2005-08	90,113
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	3.65	000	2006-04	24,066

15003	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	0.80	ZZZ	2006-04	43,311
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or	4.58	000	2006-04	32,464
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	43.28	090	2005-08	3,163
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	39.88	090	2005-08	5,001
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	090	2005-08	1,849
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	2006-04	250
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	1.73	000	2006-02	20,612
70355	Orthopantomogram (eg, panoramic x-ray)	0.20	XXX	2005-08	34,300
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	1.99	XXX	2006-04	3,816
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	1.37	XXX	2006-04	40,526
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	XXX	2005-08	5,905,780
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)	2.25	ZZZ	2005-08	560,661

2. Temporary Removal of CPT Codes Under Current RUC Review

The MPC Workgroup discussed whether MPC codes under current RUC review should be automatically removed from the MPC list until CMS finalizes their valuation. This discussion stemmed from a proposal by the American College of Surgeons (ACS) at the March 2021 Workgroup meeting for the Workgroup to temporarily remove any CPT codes that are under

current RUC review. **The Workgroup agreed that moving forward, all codes under current RUC review should be removed from the MPC.**

One current MPC code - **CPT code 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)* (List separately in addition to code for primary procedure)** – is under review for the October 2021 RUC meeting and should be removed under this recommendation.

Once it was determined by the Workgroup that AMA staff remove any codes from the MPC list that are under current RUC review, a discussion regarding reinstatement of such codes was discussed. **Once CMS finalizes a valuation for any code that is removed from the MPC for this reason, AMA staff will communicate with the specialty societies to determine whether they wish to place these codes back onto the MPC list during the annual review of MPC codes. If the specialty societies wish to place back on the MPC list, it will be placed on a consent calendar for consideration by the MPC Workgroup.**

The following codes will be considered for the reinstatement process in November 2022.

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	9.06	090	2010-10	5,470
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	0.54	ZZZ	2015-10	528,759
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	0.17	XXX	2009-10	301
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	1.92	XXX	2006-02	1,759,562

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	2.61	XXX	2006-02	6,459,408
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	XXX	2006-02	10,626,847
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	0.76	XXX	2006-02	6,736,945
99232	Subsequent hospital care, per day, for the evaluation and management of a patient,	1.39	XXX	2006-02	44,656,174

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.				
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	2.00	XXX	2006-02	24,607,697
99238	Hospital discharge day management; 30 minutes or less	1.28	XXX	2006-02	2,550,501
99239	Hospital discharge day management; more than 30 minutes	1.90	XXX	2006-02	5,189,830
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's	0.48	XXX	2018-04	67,730

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	and/or family's needs. Usually, the presenting problem(s) are self limited or minor.				
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	0.93	XXX	2018-04	352,496
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	1.60	XXX	2018-04	2,744,710
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	2.74	XXX	2018-04	5,415,650
99285	Emergency department visit for the evaluation and management of a patient,	4.00	XXX	2018-04	11,514,274

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.				
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	1.64	XXX	2007-02	336,776
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	3.06	XXX	2007-02	1,389,990
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused	1.16	XXX	2007-02	11,302,104

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.				
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	1.55	XXX	2007-02	10,009,767
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	2.35	XXX	2007-02	1,671,664
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key	1.71	XXX	2007-02	100,126

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.				
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	2.63	XXX	2007-02	57,317
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	3.46	XXX	2007-02	67,147
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.	1.72	XXX	2007-02	1,241,609

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
	Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.				
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.	2.46	XXX	2007-02	1,676,057
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.	3.58	XXX	2007-02	547,337

3. Removal of a CPT Code from MPC when the Work RVU Determined by CMS is Not Consistent with RUC Recommendation

The MPC Workgroup discussed CPT codes on the MPC list for which CMS did not accept the RUC-recommended work RVU value (there are 34 such codes on the current MPC list). The Workgroup understands that many of these services may be important to specialty societies, with few other services available for the MPC. Many of the services were reviewed years ago and the specialty societies may have accepted the CMS decision. While several MPC Workgroup members thought that codes with RUC approved values would be better comparisons, a decision was made to defer to the specialty societies.

The Workgroup recommended that specialty societies retain the right to recommend the addition to or maintenance on the MPC list of a CPT code for which CMS did not accept the RUC recommended value (i.e., a CMS adjustment should not preclude a code from being on the MPC list). The Workgroup recommended that specialties be asked to review these codes when the next request is distributed in November 2021 and notify the MPC workgroup if they wish to remove any of these services.

The MPC Workgroup recommends specialty society review of the following codes for which CMS did not accept the RUC-recommended work RVU value and notify the Workgroup if any of the following codes should be removed:

Code	Long Descriptor	2021 Work RVU	RUC Rec	Global	2019 Frequency
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.22	1.50	010	368,976
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.01	1.12	000	1,938,307
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	2.70	3.00	000	456,527
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	4.10	4.56	000	88,567
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	7.07	8.00	090	2,079
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	7.42	8.40	090	1,657
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	5.86	6.60	090	1,365
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	7.80	8.00	090	11,733
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using	58.79	59.00	090	1,812

Code	Long Descriptor	2021 Work RVU	RUC Rec	Global	2019 Frequency
	valved conduit and coronary reconstruction (eg, Bentall)				
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)	2.09	2.32	ZZZ	13,979
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	1.28	1.38	000	71,670
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	12.11	090	38,983
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	9.09	10.05	090	10,329
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	39.88	40.90	090	12,479
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	8.88	9.08	010	3,464
52000	Cystourethroscopy (separate procedure)	1.53	1.75	000	897,375
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2.75	2.80	000	62,618
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	2.82	2.83	000	151,015
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	7.50	7.88	000	11,180
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	4.00	4.50	000	26,625
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	1.01	1.20	ZZZ	101,717
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	6.55	7.73	090	5,906
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy,	14.56	15.20	090	4,687

Code	Long Descriptor	2021 Work RVU	RUC Rec	Global	2019 Frequency
	meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are inc				
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	13.36	14.00	090	1,020
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	25.18	29.07	090	1,030
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11.19	12.37	090	7,841
60500	Parathyroidectomy or exploration of parathyroid(s);	15.60	16.78	090	18,399
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	5.60	6.10	010	8,146
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	5.19	6.05	010	29,921
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	0.26	0.30	XXX	9,755
85097	Bone marrow, smear interpretation	0.94	1.00	XXX	140,727
92273	Electroretinography (ERG), with interpretation and report; full field (ie, fERG, flash ERG, Ganzfeld ERG)	0.69	0.80	XXX	68,699
92567	Tympanometry (impedance testing)	0.20	0.50	XXX	922,916
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	2.00	XXX	1

The Workgroup also discussed six End-Stage Renal Disease (ESRD) codes on the MPC list for which CMS adjusted the work RVU values without RUC review. The Workgroup recommended deferring any MPC list action with respect to these six ESRD codes until the Administrative Subcommittee reviews the codes and determines whether they should be flagged to not be used for RUC comparisons.

The MPC Workgroup recommends deferring action on the following codes until the Administrative Subcommittee determines whether to flag them to not use in RUC comparisons:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2019 Frequency
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	6.77	5.18	XXX	2,218,361
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	5.52	4.26	XXX	719,245
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month	3.57	3.15	XXX	213,048
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	5.52	4.26	XXX	365,733
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	0.33	0.29	XXX	3,635
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	0.18	0.14	XXX	940,201

4. MPC List Code Selection Criteria Update for Prospective New Codes to MPC – Consider Requirement of Work RVU Based on RUC Survey (Versus Crosswalk or Other Methodology)

The MPC Workgroup discussed adding the following criterion for codes being added to the MPC list under the MPC list's "Suggested Criteria": "Codes should have a work RVU value based on RUC survey results, as opposed to a direct work RVU crosswalk or other methodology." The Workgroup agreed that as the use of survey results is the preferred methodology, MPC codes should ideally be valued under this methodology. The Workgroup recommended that this criterion should be included under "Suggested Criteria".

The MPC Workgroup recommends amending the "MPC Code Assessment Criteria & Considerations" as highlighted below:

MPC Code Assessment Criteria & Considerations:

In maintaining the MPC list, the MPC Workgroup should consider the below criteria when assessing the appropriateness of specialty society recommendations. Furthermore, the Workgroup should pay special attention to whether the codes achieve either one of two primary purposes: 1)

the recommended codes fill a perceived work RVU gap within the entire MPC list and 2) the recommended codes fill a perceived work RVU gap within each individual specialty's current MPC codes.

Absolute Criteria:

- The codes should have current work RVUs that the specialty(s), RUC and CMS accept as valid.
- Any specialty(s) that perform(s) greater than 10% of the total utilization or greater than 10,000 billing instances of the service should have the right to consider the appropriateness of the inclusion of the service on the MPC list. The MPC Workgroup will review that request in consultation with the performing specialty(s), which shall be offered the opportunity to comment, and make a recommendation to the RUC for final determination.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

Suggested Criteria (not Absolute Requirements):

- Codes should represent a spectrum of low to high work RVUs.
- The codes should span the range of global periods for services.
- Codes should be reflective of the entire spectrum of services provided by specialty societies.
- Codes that are frequently performed should be reflected on the MPC list.
- To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties.
- Codes on the MPC list should be understood and familiar to most physicians.
- Codes with utilization of less than 1,000 should not be included on the MPC list without justification by a specialty society.
- **Codes should have a work RVU value based on RUC survey results, as opposed to a direct work RVU crosswalk or other methodology.**

Members Present: Gregory DeMeo, DO (Chair), Brook Bisbee, DPM, R. Dale Blasier, MD, Kathy Cain, MD, Daniel DeMarco, MD, William D Donovan, MD, Jeffrey Paul Edelstein, MD, Matthew Grierson, MD, Marc Raphaelson, MD, Holly Stanley, MD, Edward Toggart, MD, Doris Tomer, LCSW, James Waldorf, MD

I. Proposed Specialty Overrides for Low Volume Services

The standard process for deriving professional liability insurance (PLI) RVUs uses the most recent year's Medicare claims data to determine a specialty-weighted liability insurance premium as one of the main input into the PLI RVU formula. CMS also does a similar analysis to determine the specialty mix as part of the process for deriving the indirect practice expense portion of the PE RVUs. On occasion, a few erroneous claims with an incorrect CPT code number are present in the data CMS uses to derive PLI and indirect PE RVUs (meaning for those services the wrong specialty(ies) were used to derive the PE and PLI rvus for the impacted code). For services with a thousand or more claims, a handful of errant claims would have virtually no impact. However, for CPT codes that have very low volumes in the Medicare population, a few erroneous claims could have a large negative impact. To mitigate this issue, beginning in 2018, CMS first implemented a policy recommendation from the RUC to use single specialty override assignments for the assigned PLI risk premiums and indirect practice expense for very low volume services (those with an average of less than 100 Medicare utilization over the past 3 years). The current list, which includes over 2,000 codes, is available in the Proposed Rule addenda files.

For CY2022, AMA RUC staff performed an analysis to identify all eligible codes and put together a list of potential specialty overrides for each newly eligible service. Following the completion of the analysis and initial review, AMA Staff circulated the list to all RUC participants soliciting specialty society feedback on whether the suggested specialty override would be appropriate for each of the newly eligible service and received robust feedback. The specialty recommendations were integrated into an updated version of the spreadsheet shared with the PLI Workgroup.

The PLI Workgroup reviewed the updated proposed list of low specialty overrides for eligible services. The proposed list included 164 newly added services, reactivation of the specialty override for 327 services already on the list (though that CMS had previously found no longer eligible), and deactivation of the specialty override for 14 services that are no longer eligible. Separately, the Society of Thoracic Surgeons (STS) and American Association for Thoracic Surgery (AATS) had also submitted proposed changes for services that CMS already includes on the override list, though where STS and AATS disagree with the CMS-assigned specialty. 98 out of 104 of these recommendations are for switching the specialty override from Thoracic Surgery to Cardiac Surgery.

In previous comments to CMS, STS has recommended that the low volume specialty override (crosswalk) for PE and Malpractice should be Cardiac Surgery instead of Thoracic Surgery (or another specialty instead of cardiac/thoracic surgery) for a number of codes. To date, CMS has not made the recommended changes. The STS/AATS specialty crosswalk recommendations are based on the concept that codes that are considered "cardiac" in nature should be listed as "Cardiac Surgery" and that codes that are considered "Thoracic Surgery" in nature should be listed to Thoracic Surgery and that is how STS/AATS have determined their recommended crosswalk specialty for each code listed.

Following review of specialty society feedback, the PLI Workgroup revised the initially proposed specialty overrides from AMA staff for a subset of the codes as follows:

CPT Code	Short Descriptor	Specialty Override Approved By PLI Workgroup (codes modified from original AMA Staff Proposal)
21603	EXC CH WAL TUM W/LYMPHADEC	THORACIC SURGERY
26665	TREAT THUMB FRACTURE	HAND SURGERY
31781	RECONSTRUCT WINDPIPE	OTOLARYNGOLOGY
33910	REMOVE LUNG ARTERY EMBOLI	CARDIAC SURGERY
35180	REPAIR BLOOD VESSEL LESION	VASCULAR SURGERY
39503	REPAIR OF DIAPHRAGM HERNIA	THORACIC SURGERY
43313	ESOPHAGOPLASTY CONGENITAL	GENERAL SURGERY
43314	TRACHEO-ESOPHAGOPLASTY CONG	GENERAL SURGERY
95857	CHOLINESTERASE CHALLENGE	NEUROLOGY
96440	CHEMOTHERAPY INTRACAVITARY	HEMATOLOGY ONCOLOGY
G0106	COLON CA SCREEN;BARIUM ENEM	DIAGNOSTIC RADIOLOGY
G0118	GLAUCOMA SCR N HGH RISK DIRE	OPTOMETRY
G0120	COLON CA SCR N; BARIUM ENEMA	DIAGNOSTIC RADIOLOGY
G0128	CORF SKILLED NURSING SERVIC	INTERNAL MEDICINE
G0329	ELECTROMAGNTIC TX FOR ULCER	PHYSICAL THERAPY
G0341	PERCUTANEOUS ISLET CELLTRAN	INTERVENTIONAL RADIOLOGY
G0409	CORF RELATED SERV 15 MINS E	LISCENSED CLINICAL SOCIAL WORKER
G2006	POST-D/C H VST EXT PT 20 M	INTERNAL MEDICINE
G2251	BRIEF CHKIN, 5-10, NON-E/M	PHYSICAL THERAPY*
<i>And 98 Additional Codes from Thoracic Surgery to Cardiac Surgery</i>		

**Note, on the conference call, the Workgroup indicated that G2251 should be internal medicine. However, following the call, a stakeholder shared that the CY2021 MPFS final rule stated that G2251 was created for non-physician practitioners and physical therapy was the first one listed. In addition, the code's long descriptor specifically states that the service is for "...a qualified health care professional who cannot report evaluation and management services."*

The PLI Workgroup approved the proposed list of Expected Specialty Recommendations for Low Volume Codes for CY2022 NPRM Comment with the above changes distinct from the original proposed list circulated by AMA staff to all RUC participants. This document will be collated into one list and sent to CMS as part of the RUC comment letter.

II. Review of Draft RUC Comment Letter Section on PLI

The Professional Liability Insurance (PLI) Workgroup was asked to review and approve the PLI portion of the RUC's draft comment letter on the CMS *Proposed Rule* on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2022. The Workgroup agreed that the draft content prepared by AMA RUC Staff was appropriate and did not have any suggested changes.

III. New Business

STS and AATS noted that the malpractice adjustment factor for thoracic surgery (6.45) is slightly higher than that for cardiac surgery (6.37) and that having thoracic surgery as slightly higher than cardiac surgery is possible incorrect. The STS has commented on this in several of the rules as well asking CMS for clarification on why the thoracic surgery malpractice risk factor is higher than the cardiac surgery malpractice risk factor. The Workgroup concurred that the relationship is unexpected though requested for the societies to submit data demonstrating that the current malpractice risk factors are incorrect.

Members Present: Doctors John Proctor (Chair), Kathy Cain (Vice Chair), Jennifer Aloff, Sergio Bartakian, William Donovan, Matthew Grierson, Gregory Harris, Gwenn Jackson, Katie Jordan, OTD, Peter Manes, Eileen Moynihan, Stephen Sentovich, Holly Stanley and David Wilkinson.

I. Re-review of Services

High Volume Growth (77014)

In October 2015, CPT code 77014 *Computed tomography guidance for placement of radiation therapy fields* was identified via the high volume growth screen. In January 2016, the Relativity Assessment Workgroup (RAW) noted that this service is part of the radiation oncology code set held by CMS and that it was referred to CPT for review. The Workgroup determined that it should review utilization data when available. The Protecting Access to Medicare Act of 2014 (PAMA) included a special subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by the Healthcare Common Procedure Coding System [HCPCS] G-codes G6001 through G6015) for the physician payment schedule established under this subsection for services furnished in 2017 and 2018. These services were designated to maintain the same definitions, units, and inputs for such services included in the fee schedule established in 2016. In 2018, these services remained replaced by G codes by CMS. The RUC in 2018 recommended that if CMS did not address these services in the Notice of Proposed Rulemaking (NPRM) for 2020, the Relativity Assessment Workgroup would review again in October 2019 to determine next steps. In October 2019, the Workgroup discussed this issue and determined that it should allow the specialties to continue to work with CMS pursuant to implementation of the 2015 radiation treatment delivery codes and schedule Workgroup review again in two years.

In August 2021, the specialty societies informed the Relativity Assessment Workgroup that in July 2021, CMS released modifications to the Radiation Oncology-Advanced Alternative Payment Model (RO-APM) as part of the 2022 rule making cycle. In the interest of rate setting for the RO Model roll out and early payment stability, maintenance of the components of the RO-APM is viewed as critical. Additionally, the specialty societies indicated that the growth in 77014 is consistent with the standard growth in cancer treatments. As such, the specialty societies requested maintenance of the inputs for CPT Code 77014 and removal from the high-volume growth screen. The Relativity Assessment Workgroup agreed that stability for the RO-APM is important and that the growth of 77014 is appropriate. **The Workgroup recommends maintaining CPT code 77014 and removing it from the current high volume growth screen.**

CMS/Other Source – Medicare Utilization over 20,000 (G0506)

In October 2020, the RUC identified code G0506 *Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)* as CMS/Other Source – Medicare Utilization over 20,000. The Workgroup requested that an action plan be reviewed at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or this G code should be surveyed. In January 2021, the RUC recommended to allow changes to the Principal Care Management/Chronic Care Management codes to occur (January 2021 RUC meeting). The specialty societies assessed the NRPM for 2022 (released July 2021) response from CMS noting that CMS did not delete G0506. Subsequently, the specialty societies submitted an action plan stating that the RUC should request that CMS delete G0506, as it is already reportable by CPT code 99491 *Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional*

decline; comprehensive care plan established, implemented, revised, or monitored. The Workgroup agrees with specialty societies’ action plan as proposed and requests that CMS delete G0506 for the Final Rule for 2022, as this service may be reported with CPT code 99491.

II. Informational Items

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

Members Present: Scott Manaker, MD, PhD, (Chair), Amy Aronsky, DO, Gregory Barkley, MD, John Blebea, MD, Michael Booker, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal Cohen, MD, Leisha Eiten, AuD, William Gee, MD, David Han, MD, Mollie MacCormack, MD, Dheeraj Mahajan, MD, Bradley Marple, MD, Tye Ouzounian, MD, Rick Rausch, DPT, MBA, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, Thomas Weida, MD, Adam Weinstein, MD, and Jordan Pritzker, MD (CPT Resource).

I. Removal of Bubble Contrast (SD332) Supply Item from Practice Expense for Contrast Enhanced Ultrasound Codes 76978 and 76979

The Practice Expense (PE) Subcommittee considered a request from the American College of Radiology that SD332 *bubble contrast*, an ultrasound-specific contrast agent, be removed from the supply inputs for CPT codes 76978 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion* and 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)*. The contrast agent used for these procedures is separately reported using existing HCPCS Level II supply codes, such as Q9950 *Injection, sulfur hexafluoride lipid microspheres, per ml*. Thus, this new supply item recommended with the two new contrast-enhanced ultrasound codes at the January 2018 RUC meeting, and later assigned supply code SD332 by CMS, is not needed because contrast agents are billed separately via Q codes. **The PE Subcommittee recommends that the RUC request for CMS to remove supply code SD332 *bubble contrast* from CPT codes 76978 and 76979 and the Direct PE Inputs Medical Supplies Listing. The PE Subcommittee also recommends that the AMA staff consider whether the supplies list and submitted spreadsheets can be screened for separately billable items from the HCPCS codes.**

II. Clinical Staff Pre-Time Package for Major Surgical Procedures (New 000 or Conversion from 090 to 000 day global)

At the April 2021 RUC meeting, the PE Subcommittee presented its report of the Pre-Service Time Global Conversion Workgroup which determined that the current process of handling the codes with conversions in global periods from 90-day to 000- or 010-day on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for these procedures. The Workgroup agreed that trying to decide if procedures fit into certain packages would be difficult and that the current process where the specialty provides evidence is fairer than making a code fit a package and in the best interest of the specialties to be able to advocate for the appropriate pre-time. The RUC agreed with the recommendation that there should be no change in how conversion codes are handled regarding pre-service clinical staff time. It should be noted that this was the third such workgroup addressing the issue of clinical staff pre-time packages in the past 20 months.

However, the intention of CMS to fully utilize pre-service time packages was demonstrated with the release of the CY 2022 Proposed Rule in July 2021 wherein the Agency clearly relies on pre-service time packages despite RUC recommendations justifying varied pre-times for specific codes. Below is an excerpt from the RUC's comment letter submitted to CMS on August 31, 2021:

In two separate instances in the Proposed Rule, CMS is proposing to refine the facility pre-service clinical labor times for major procedures to conform to the 000- or 010-day global period

standards for “Extensive use of clinical staff” despite the RUC recommendation of standard 090-day preservice clinical labor times. The RUC notes that these procedures are performed under general anesthesia in the facility setting and require specialized supplies and equipment and pre-operative coordination between multiple specialists necessitating office clinical staff time typical of 90-day global procedures performed in the facility setting. Please refer to the RUC comments for CPT codes 46020 and 46030 and CPT codes 617X1 and 617X2 for further discussion.

The RUC recognizes that there is an initial presumption of zero minutes for pre-service clinical staff time for 000- and 010-day global periods and maintains that it is most appropriate for the specialties to be able to continue to advocate for the appropriate pre-service time for any service, regardless of the assigned global period. The RUC also recognizes that, with supportive evidence, some subset of codes may require extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). CMS reassignment of global periods for select codes does not negate the fact that a major procedure is a major procedure and the pre-service facility clinical staff time for a major procedure is independent of the global period assignment. Each procedure should be evaluated on a case-by-case basis.

The RUC will review this issue in October 2021 as it will be an item on the Practice Expense Subcommittee agenda.

Due to CMS’ reliance on packages for pre-service clinical staff times, the surgical specialties submitted a letter to request that the PE Subcommittee re-assess the need to add an additional facility category for major surgical procedures to the 0-day and 10-day global chart of pre-service clinical staff times.

The PE Subcommittee discussed the request of the surgical specialties and the recent Workgroup report and determined that a new, fourth PE Workgroup should be created to determine whether the addition of another pre-service time package is warranted. The Chair indicated that the composition of the workgroup will consist of some former members but mostly new members to try to develop a novel, innovative yet comprehensive solution to this recurring issue. CMS expressed willingness to have a continued dialogue on the issue of pre-service clinical staff time surrounding conversions in global periods.

III. Practice Expense Recommendations for CPT 2023:

Tab	Title	PE Input Changes	Consent Calendar
4	Endovascular Pulmonary Arterial Revascularization	No Direct PE Inputs	X
5	Somatic Nerve Injections	No Changes	
6	Transcutaneous Passive Implant-Temporal Bone	No Changes	
7	Prolonged Psychotherapy	Not under consideration Deleted by CPT	X

Tab	Title	PE Input Changes	Consent Calendar
8	Pulmonary Angiography	No Direct PE Inputs	X
9	Quantitative Pupillometry Services	No Changes	
10	Inpatient and Observation Care Services	No Changes	
11	Consultations	No Changes	
12	Nursing Facility Discharge Day Services	No Changes Affirmation	X
13	Home and Residence Services	Modifications	
14	Prolonged Service – Without Direct Patient Contact	Modifications	
15	Prolonged Services – on the Date of an E/M	Modifications	
16	Contrast X-Ray of Knee Joint	No Changes	
17	3D Rendering with Interpretation and Report	No Changes	
24	SARS-CoV2-IA-Boosters, Pfizer Tris-Sucrose, Pfizer Age 5-11	No Changes	

Members Present: Christopher Senkowski, MD (Chair), Alan Lazaroff, MD (Vice Chair), James Blankenship, MD, R. Dale Blasier, MD, Jim Clark, MD, Gregory DeMeo, DO, Jeffrey Paul Edelstein, MD, Peter Hollmann, MD, Omar Hussain, MD, M. Douglas Leahy, MD, Paul Pessis, AuD, Marc Raphaelson, MD, Sanjay Anantha Samy, MD, James Shoemaker Jr, MD, David Slotwiner, MD, Stanley W. Stead, MD, Edward Vates, MD, Mark Villa, MD, David Yankura, MD

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

The Research Subcommittee report from the May 24th conference call included in Tab 22 of the October 2021 agenda materials was approved without modification.

II. Discussion – Intra-Work Per Unit Time (IWPUT) Comparisons

At the April 2019 RUC meeting, the RUC (vote 27-1) recommended for the full increase of work and physician time for office visits to be incorporated into the surgical global periods for each CPT code with bundled post-operative office visits. CMS decided to not accept this RUC recommendation, resulting in bundled post-operative office visits in the surgical global period having divergent lower values relative to separately reported office visits. Due to CMS' decision, the RUC Database and the Intra-service Work Per Unit of Time (IWPUT) calculator spreadsheet continue to use the 2020 office visit work values as inputs to the IWPUT formula.

At the January 2021 RUC meeting, a RUC member requested that the Research Subcommittee review the impact to IWPUT comparisons based on CMS' decision. The RUC agreed to refer this request to the Research Subcommittee to review the impact on IWPUT comparisons. To facilitate this discussion, AMA Staff had provided the Subcommittee with an analysis comparing the IWPUT for high volume 010-day and 090-day codes before and after adjusting the IWPUT formula inputs for the 2021 office visit increase.

The Chair began the discussion by providing a brief overview of the CMS decision and the Subcommittee's previous deliberations on the IWPUT formula. The pre-service 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. These intensities are widely divergent from the work per unit time for separately reported office visit services (0.04). After discussing this issue over several meetings, the Research Subcommittee and the RUC approved in October 2020 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, 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.

The Subcommittee reiterated its concern, previously discussed at its meeting in March, that the IWPUT formula has lost some validity and utility. The Subcommittee noted that the IWPUT metric still has strong utility within a code family and some utility when comparing recently reviewed services with the same global period and similar lengths of physician time. However, it has lost a lot of its relevance with respect to comparing services with different global periods, large differences in time and/or that were reviewed many years apart from each other.

AMA Staff noted that the IWPUT metric is not in any of the AMA's public facing data products and the Subcommittee noted that continuing to only use this metric internally is most appropriate.

The Research Subcommittee recommends for IWPUT to continue to be used internally in the RUC summary spreadsheets and in the RUC Database.

III. Work Per Unit Time (WPUT) Analysis

During the *New Business* discussion at the April 2021 RUC meeting, a RUC member requested that staff perform an analysis for the Research Subcommittee to have a general discussion about Work Per Unit Time (WPUT). This analysis, which summarizes WPUT by global period and code ranges, is included in the Research Subcommittee agenda materials (file *03b WPUT Analysis*).

The Chair noted that there is no specific action that is being requested of the Subcommittee and that this analysis was provided to spur a general discussion. It was also noted that, in 2020, WPUT was added to the RUC summary spreadsheet. Several Subcommittee members noted that this metric has been a helpful addition and has some overlapping utility with the IWPUT data point.

AMA staff noted that the volume-weighted, median and mean WPUTs included in the analysis were relatively closer to each other compared to what many may have predicted prior to seeing the analysis. Also, it was noted that these represent averages and mid-points and individual services will have variance depending on their work intensity. It was also noted that ZZZ add-on codes have the highest WPUT, and that can be attributed to these services largely only including skin-to-skin for face-to-face time. The Subcommittee noted that the median and percentiles datapoints were of the most interest. The Research Subcommittee had decided that no further action was needed, as the WPUT metric is already included in the RUC summary spreadsheet. The Research Subcommittee and the RUC will continue to monitor the use and validity of the WPUT metric.

IV. Review of Proposed Updated Targeted Sample Guidelines

At the March 2021 Subcommittee meeting, AMA staff suggested an alternative where societies could use targeted survey sample methodology provided they comply with a list of specific requirements. At that meeting, the Research Subcommittee approved that certain targeted survey sample requests would no longer need to be reviewed and approved by the Subcommittee provided they meet certain criteria ensuring the vendor provides its complete list and the survey population also includes a simple random sample or a random sample of applicable subset of each society's membership. AMA staff, the Chair and the Vice Chair worked together to draft proposed text for the Subcommittee's consideration during this meeting. It was noted that targeted sample requests that involve vendor lists are only done currently for services that involve new technology or very low volume.

The Research Subcommittee approved the following changes to section 3 of the Research Subcommittee Guidelines and Requirements document:

Survey Sample Methodology:

- a. **Review Requirements:** The RUC expects ACs to use a random survey to develop relative value recommendations and should disclose the process used and the population sampled in the rationale section of Summary of Recommendation (SOR) form. Use of either a ***Simple Random Sample*** ([*Addendum A-I*](#)) or a ***Random Sample of Applicable Subset(s)*** ([*Addendum A-II*](#)) for a RUC survey does not require Research Subcommittee approval. **In addition, use of a vendor-**

provided list of all trained US providers known to the vendor does not require Research Subcommittee approval, provided that the vendor signs the RUC vendor attestation statement prior to the launch of the survey and the survey sample also includes either a simple random sample or a random sample of applicable subset(s) of each participating society's membership.

If a specialty intends to use any other survey sample method, defined as a *Targeted Sample* ([Addendum A-III](#)), they must request review and approval by the Research Subcommittee prior to surveying the code(s). Also, if you plan to request data from a vendor for direct practice expense information, you must also submit the request in advance to the Research Subcommittee.

- b. **Submission Requirements:** Submission must define the source of any proposed targeted sample and should explicitly state whether the AC intends to use only a targeted survey sample, both targeted and random samples or a survey which includes all names on the targeted list. Inclusion of a short-written rationale with your Research Subcommittee request is strongly recommended.
- c. **Requirements pertaining to your RUC Submission and Presentation:**
 - i. If a Research Subcommittee approved “targeted survey” consists of contact information provided from a company/vendor, the specialty society must have the company/vendor sign the [RUC Company/Vendor Attestation Statement](#) stating no further communication regarding the survey or valuation occurred.
 - ii. If ~~your the Research Subcommittee approves of~~ survey sample methodology ~~which~~ includes both a targeted sample and a random sample, the summary data would need to have targeted and random samples presented separately and together to the RUC. The summary data must be listed both separately and together in the summary excel spreadsheet and the SOR rationale section must summarize the separated and aggregated survey data.

Addendum A: Terms and Definitions

- I. Simple Random Sample:** A randomly selected subset of a society's general US membership with available email addresses, excluding RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees. Each individual in the subset is chosen randomly, such that each individual has the same probability of being chosen. The use of this sampling methodology does not require approval from the Research Subcommittee.
- II. Random Sample of Applicable Subset(s):** Sampling from one or more subsets of a society's US membership with available email addresses based on certain subset characteristics, excluding RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees. The goal of this methodology is to distribute surveys to those members of a society that are most likely to be familiar with or have experience performing the service under review. A random sample from each applicable subset, where each individual in the subset has the same probability of being chosen, should be taken. Whenever using multiple subsets, the Advisory Committee should endeavor to make the proportion of each subset analogous to the estimated demographics of the providers performing the service under review.

Subset characteristics of the specialty society that do not require Research Subcommittee approval are:

- Subspecialty certification or designation
- Member has indicated experience with a certain modality, body region or diagnoses
- Inclusion in an established specialty society member section

When using this sampling methodology, clearly explain how the sample was derived on the RUC Summary of Recommendations form under *Description of Sample*.

- III) Targeted Sample:** Any sampling method which falls outside the definition of a Simple Random Sample or a Random Sample of Applicable Subset. The goal of this methodology is to distribute surveys to **physicians or other qualified healthcare providers those members of a society** that are most likely to be familiar with or have experience performing the service under review. Any list provided by industry is classified as a targeted sample. RUC members, alternate RUC members, HCPAC members, alternate HCPAC members, students, post-graduate trainees and retirees should be excluded. All targeted samples must be approved by the Research Subcommittee. When using this sampling methodology, clearly explain how the sample was derived on the RUC Summary of Recommendations form under *Description of Sample*.

V. Pre-time Packages for Pediatric Major Surgical Services

During *New Business* at the April 2021 RUC meeting, a RUC member requested that the Research Subcommittee review whether it would be appropriate to create pre-service time packages for pediatric major surgical procedures. AMA staff had noted that the relevant specialty societies performing these services should share recommendations with the Research Subcommittee.

The American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) submitted a proposal for additional pre- and post-service packages specifically for complex congenital cardiac procedures. The request is included in the Research Subcommittee agenda materials (file *05b ACC SCAI Requested additional pre-time and post-time packages for complex congenital cardiac procedures*).

The specialty presenter gave an overview of the request from ACC and SCAI to recommend a standard 10 additional minutes for pre-service evaluation, 1 additional minute for scrub/dress/wait, 3 additional minutes for positioning and 28 additional minutes for immediate post-service time for complex congenital cardiac procedures. They noted that the existing standard pre- and post-service packages do not accurately align to the work performed in a children's hospital, particularly for the patient with congenital heart disease in the cardiac catheterization laboratory or cardiac surgical suite.

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

It was noted that the standard pre-service time packages have additional standard positioning time for major surgical spine procedures. However, it was also separately noted that these standard additions only pertain to pre-service positioning and there are currently no procedure-specific time standard times for pre-service evaluation, pre-service scrub/dress/wait or immediate post-service time.

The Research Subcommittee questioned whether the proposed time packages would also cover relatively less complicated procedures or also be applied to relatively older children. Several Subcommittee members noted that they did not think the current time packages act as a barrier, noting that after being discussed, the RUC recommended physician times for the cardiac catheterization and congenital coarctation code families had RUC-recommended times that well exceeded the standard time packages and largely aligned with the societies proposal. Also, several Subcommittee members noted there are many other groups of major surgical procedures that have pre- and post-service work that is also not captured in the standard packages. **The Research Subcommittee agreed that creating new time packages would not be needed at this time for complex congenital cardiac procedures. The Research Subcommittee does not support the creation of specific complex congenital cardiac time packages. The Research Subcommittee recommends maintaining the current method for specialty societies to advocate for more pre-service and post-service time over the standard pre-service and post-service packages when applicable.**

A Subcommittee member also suggested for the societies to consider maintaining their own internal standards linked to precedent for services that were recently RUC reviewed. The societies could cite these precedents when presenting new sets of codes to the RUC as support.

VI. Discussion – 23-hour Stay CMS Policy and ½ Day Discharge Visits *(referred from April 2021 RUC New Business)*

At the April 2021 RUC meeting, the American Academy of Orthopaedic Surgeons (AAOS) submitted a memo to the RUC expressing concerns about the 23-hour stay and half-day discharge policies and their implementation. This request is included in the Research Subcommittee Agenda Materials (*05b Request from AAOS - 23-hr stay policy*).

CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (eg 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. Prior to the CY2011 Final Rule, the RUC has used 0.5 x 99238 as a proxy for same-day outpatient discharge. Though in the CY2011 Final Rule, CMS expanded the ½ day discharge proxy to all outpatient services, including if the patient stays overnight though less than 24 hours — the RUC has also implemented this change following the release of the CY2011 Final Rule.

The Research Subcommittee unanimously agreed that applying the ½ Day Discharge policy to services that have an overnight stay less than 24 hours is flawed and that CMS should modify the policy to only apply the ½ day discharge proxy to services that typically involve a same-day discharge. The Subcommittee noted that, if these services were 000-day global where the patient stayed overnight and was discharged the next day, then a full discharge visit could be reported on the next day — therefore, it is inappropriate to use a ½ day discharge for any services that typically involve an overnight stay.

A Subcommittee member observed that, since CPT modified the inpatient visits for CPT 2023 to be reported based on total time on the date of the encounter and the Research Subcommittee had approved for only total time on the date of the encounter to be surveyed, then the intra-service time and the total time would be

identical (if CMS implements these recommendations). Therefore, if CMS adopts those recommendations, CMS' policy to allocate the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of an outpatient procedure would no longer have any impact.

After briefly discussing whether the Research Subcommittee should both recommend for the RUC and the AMA to advocate for CMS to change its policies and for the RUC to change its rules for these services, the Subcommittee decided it would be best for CMS to first agree to the change prior to the RUC handling these services differently.

The Research Subcommittee recommends for the RUC Chair and the AMA to meet to advocate for CMS to change its policy for discharge day visits in the surgical global period, where the ½ day discharge proxy would only be applicable to services that typically involve a same-day discharge. Similarly, the Research Subcommittee recommends for the RUC Chair and the AMA to meet to advocate for CMS to eliminate its 23-hour stay policy of allocating the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of an outpatient procedure. The Research Subcommittee also recommends for an update on this meeting to be provided to the RUC after it takes place.

VII. Discussion – Review of Services Undergoing Global Period Change

At the October 2020 RUC meeting, a RUC member requested policies to be developed regarding how neutral evaluation of codes undergoing a change in global period should be best accomplished and broadly representative. Currently, there is no formal transition underway, global period changes have occurred 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. The RUC referred this issue to the Research Subcommittee to discuss the process for reviewing services with a proposed global period change, and whether any new policies should be developed.

There were three code families that had codes with global period changes from either 090-day or 010-day to 000-day during the CPT 2022 cycle, and one code family thus far during the CPT 2023 cycle. The Vice Chair noted the concern that it is unclear when compelling evidence should be required for code families that are undergoing global period conversions. He also noted that it would not be viable to simply compare the 010-day or 090-day code to the 000-day global version of the same service with all the previously bundled visits, as for many of these services, the post-operative work has changed relative to when the service was last reviewed sometimes 10+ years previously. Also, certain services have IWPUTs that are near zero or negative, which would leave essentially no value for the procedure itself if some sort of formulaic approach were implemented. It was also noted that all of the tabs presented so far have included compelling evidence. And that CMS rejected the majority of these valuations in recent proposed rule. Chair noted that the discussion is warranted but any policies would be premature.

Other Subcommittee members expressed concern that since these services were valued using magnitude estimation that engaging in straight reverse building block methodology would not be appropriate. The Vice Chair concurred that straight reverse building block would not be a viable pathway. A Subcommittee member offered that perhaps a process could be first tested with 010-day global services as they would be less challenging to value than 090-day global services.

Another Subcommittee member offered a separate idea regarding a process to determine compelling evidence for these services. that would not be a straight reverse building block. They suggested that presenting societies could also make a recommendation as to what they anticipate to be the typical number and level of separately

reported post-operative visits — then the RUC could use those projected separately reported visits as part of its budget neutrality calculation to determine whether compelling evidence is required.

The Vice Chair suggested that a few questions could be circulated electronically to the Research Subcommittee for each member to provide written feedback. This written feedback could be summarized and reviewed at the Subcommittee's next meeting. The Subcommittee concurred that this exercise would be beneficial. The Subcommittee agreed to continue this discussion at its next meeting coinciding with the January 2022 RUC meeting.

Members Present: Doctors Margie Andreae (Chair), James Waldorf, Amr Abouleish, Kris Anderson, DC, Daniel DeMarco, Timothy Laing, Lance Manning, John McAllister, Guy Orangio, M. Eugene Sherman, Matthew Sideman, Clarice Sinn, Karen Smith, MS, MBA, RD, Donna Sweet and Robert Zwolak.

I. CMS Increased the RVW for a Group of Codes independent of a RUC Review (2021)

For CY 2021, CMS proposed and finalized increases for services they stated were analogous to the E/M office visit codes (99202-99215) increased for 2021. The list of codes CMS increased varied widely; some of these services had been previously crosswalked to an E/M office visit, used E/M office visits as a building block, included an E/M office visits as part of the service, or the service was compared to an E/M office visit as a reference point.

At the April 2021 RUC meeting when the RUC was reviewing services that were compared to the 2021 CMS increased codes, the RUC had difficulty assessing the relativity to the services under review. The RUC noted that some services may have warranted an increase due to the relationship with an E/M office visit; however, the list of codes that CMS adjusted were not based on a recent RUC review or recommendation and the increases were applied irregularly. In April 2021, the RUC did not use the 2021 CMS increased codes as comparators for relativity. A RUC member requested that these services be identified and discussed on how to address for the future.

In September 2021, the Subcommittee stated concern that the 2021 CMS valuation of these services was not based on standard RUC process – thus a survey with magnitude estimation by the physicians who perform these services, a RUC review and recommendation relative to other services, nor a CMS review and acceptance or refinement was used to establish a relative value. The Subcommittee noted that because the values for these codes did not follow the standard RUC/CMS process, using these codes as comparators or crosswalks in the RUC valuation process would disrupt the integrity of the relativity of services in the database. Basing the value of services in the Medicare Payment Schedule on services that were not established following RUC process appropriately defies the purpose of the RUC – The AMA/Specialty Society *Relative Value Scale* Update Committee.

The Subcommittee acknowledges that the RUC accepts the CMS valuation for services as the current valuation; however, the RUC should not use specific services for comparison that the RUC believes were valued outside of RUC processes, including CMS altering values independent of a RUC recommendation.

The Administrative Subcommittee recommends the RUC flag these 44 services as “Do not use to validate physician work” in the RUC database. *See list of 43 codes below.* The Subcommittee noted that nine of these services (90960, 90961, 90962, 90966, 90969, 90970, 99283, 99284, 99285) are currently on the MPC list, therefore, will subsequently be removed by the MPC Workgroup since they are flagged as “Do not use to validate work”.

The RUC added that it will place these services on the level of interest for all specialty societies to indicate whether they would like to survey these services or leave as “do not use to validate physician work”.

The RUC noted that it reviewed CPT codes 99283, 99284, 99285 and 99483 in April 2021 for CPT 2023. These codes should be flagged as “Do not use for validation of physician work” until 2023 after CMS makes its final determination based on the most recent RUC review. However, these four codes do not need to be on the level of interest since they were recently surveyed.

90791	90956	90963	92521	97164	99285	G0438
90792	90957	90964	92522	97165	99483	G0439
90832	90958	90965	92523	97166	99492	
90834	90959	90966	92524	97167	99493	
90837	90960	90968	97161	97168	99495	
90951	90961	90969	97162	99283	99496	
90954	90962	90970	97163	99284	G0402	

II. Historical Information on Current Work RVU and RUC Reviewed Codes

In April 2021, a RUC member requested that AMA Staff conduct an environmental scan and provide historical information to the Administrative Subcommittee regarding the rules regarding determining work neutrality, compelling evidence and which codes are considered RUC reviewed, as well as provide information about codes that CMS did not accept RUC recommendations.

AMA staff provided information on its policies that the current value is the CMS value, work neutrality, compelling evidence, RUC review date information and physician time source information. When reviewing the compelling evidence historical information, a Subcommittee member noted that there was more specific information regarding what the RUC considers flawed mechanisms or methodology and the Subcommittee should review again to consider adding more information to its process document. **The Administrative Subcommittee will review the compelling evidence standards and consider specifying standards such as: If a specialty society is presenting a code that was most recently finalized by CMS with a lower work RVU than the previous RUC recommended value, the specialty society may present compelling evidence that that service was based on “flawed methodology” and outline the incorrect methodology (e.g., low survey data point or no specific crosswalk or rationale provided) at a future meeting.**

III. CMS Final Value Not Consistent with RUC Value

RUC Flags

AMA Staff identified 706 services in which the RUC recommended work RVU was not accepted by CMS.

- Of these services, 385 are already flagged as “CMS Did Not Accept the RUC or HCPAC Recommendation”
- 26 of these services are flagged as “Do Not Use for Validation of Physician Work”
- The remaining 295 do not have any flag notifications
 - Of those that do not have a flag notification, 250 or 85% have 2019e Medicare Utilization under 30,000.
 - All 295 codes that do not have a flag notification were reviewed more than 10 years ago (1992-2011).

Of note, 9% or 680 of the 7,600 codes with a work RVU are based on altered RUC recommendations. A Subcommittee member suggested that the RUC’s compelling evidence standards be revised to specifically state that codes in this category (CMS adjusted RUC recommendations) are categorized as flawed methodology. This is the intent of the flawed methodology rationale; however, the Administrative Subcommittee will consider clarifying language at a future meeting.

The Administrative Subcommittee agreed that any code where CMS did not accept the RUC recommendation should be flagged as “CMS Did Not Accept the RUC or HCPAC Recommendation” to easily identify this feature of these codes in the database. The Subcommittee acknowledged that the RUC may still use these “CMS did not accept the RUC recommendation” flagged services as references or crosswalks if the specialty societies agree with the current CMS value. However, these flags alert RUC Members and Advisors immediately and allow further discussion on the specialty’s acceptance of the current value before relying heavily on an inappropriate code for valuation. **The Administrative Subcommittee recommends flagging all services since 1992, in which CMS did not accept a RUC recommendation with “CMS Did Not Accept the RUC (or HCPAC when appropriate) Recommendation”.**

Members Present: Margie Andreae, MD (Chair), Sergio Bartakian, MD, James Blankenship, MD, Jim Clark, MD, Scott Collins, MD, Daniel DeMarco, MD, Jeffrey Edelstein, MD, Bradley Marple, MD, Rick Rausch DPT, MBA, G. Edward Vates, MD

99244 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

The facilitation committee reviewed the survey results for CPT code 99244 and determined that the survey median somewhat overestimated the work typically required to perform this service. After thorough discussion, the committee recommends a direct work RVU crosswalk to CPT code 93315 *Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report* (work RVU= 2.69, intra-service time of 40 minutes, total time of 65 minutes), noting that both services involve an identical amount of total time and a similar amount of physician work. The committee recommends 40 minutes of date of encounter time and 60 minutes total time. The committee compared the survey code to top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes) and concurred that 99244 should be valued with a slightly higher intensity relative to 99204 and referenced that a 63 percent of the survey respondents that selected this top KRS had indicated that the 99244 is more intense/complex. **The facilitation committee recommends a work RVU of 2.69 for CPT code 99244.**

99245 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making

The facilitation committee reviewed the survey results for CPT code 99245 and determined that the survey median appropriately valued the work typically required to perform this service. The Committee noted that there is a dearth of potential crosswalks with an XXX global period that would be appropriate for consideration. The committee compared the survey code to top key reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU= 3.50, total time of 88 minutes) and concurred that 99245 should be valued with a slightly higher intensity relative to 99205 and referenced that a 67 percent of the survey respondents that selected this top KRS had indicated that the 99245 is more intense/complex. The Facilitation Committee referenced CPT code 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)* (work RVU= 3.86, intra-service time of 55 minutes, total time of 75 minutes) and CPT Code 44390 *Colonoscopy through stoma; with removal of foreign body(s)* (work RVU= 3.74, intra-service time of 35 minutes, total time of 77 minutes). **The facilitation committee recommends a work RVU of 3.75 for CPT code 99245.**

99242 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

99243 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making

The facilitation committee noted that the RUC already voted on and approved the times and values for 99242 and 99243. The committee believes that its recommendations below, which include the same times and values for 99242 and 99243, would assign appropriate relativity within the ED visit code family.

Facilitation Committee Recommended Times and Work Values:

CPT Code	Up to 3 days before Date of Procedure Time	Day of Procedure Time	Up to 7 days after Date of Procedure Time	Recommended work RVU	Work Per Unit Time	Comment
99242	5	20	5	1.08	0.036	Survey Median
99243	7	30	7	1.80	0.041	Survey Median
99244	10	40	10	2.69	0.045	Direct work RVU Crosswalk to 93315
99245	15	55	17	3.75	0.043	Survey Median

Facilitation Committee CPT Descriptor Time Recommendations:

CPT Code	Time on the Date of Encounter Rec to CPT
99242	20
99243	30
99244	40
99245	55

Practice Expense

The Practice Expense Subcommittee approved the direct practice expense inputs as submitted by the specialty societies without modification. **The Facilitation Committee recommends the practice expense inputs as approved by the PE Subcommittee.**

Inpatient Consultations (99252-99255)

The facilitation committee noted that the RUC had recommended for Inpatient Consultation codes to be resurveyed using an updated survey instrument for the January 2022 RUC meeting and concurred with that decision.

**AMA/Specialty Society RVS Update Committee
Nursing Facility Discharge Day Services
Facilitation Committee #1 Report**

Tab 12

Members: Doctors Margie Andrae (Chair), Sergio Bartakian, James Blankenship, Jim Clark, Scott Collins, Daniel DeMarco, Jeffrey Edelstein, Lauren Golding, Bradley Marple, Richard Rausch, DPT, G. Edward Vates.

99315 Nursing facility discharge day management; 30 minutes or less

The Facilitation Committee reviewed the survey results and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The Committee recommends 10 minutes of pre-service evaluation time, 25 minutes of intra-service time and 5 minutes of post-service time.

The Committee compared 99315 to nursing facility visit code 99304 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 1.50) and determined that these services were surveyed by the same set of respondents back in April and require the same intra-service time of 25 minutes and similar total time, 40 and 36 minutes respectively. To support the recommended work RVU of 1.50, the Facilitation Committee referenced services that require similar physician work and time such as CPT code 78830 *Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging* (work RVU = 1.49 and 25 minutes intra-service time) and 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* (work RVU = 1.46 and 20 minutes intra-service time).

The Facilitation Committee agreed that 99315 compared to additional services referenced by the specialty societies in the table below supports the specialty society recommended survey 25th percentile work RVU. **The Facilitation Committee recommends a work RVU of 1.50 for CPT code 99315.**

99315 Comparison Codes						
Code	Descriptor	Global	wRVU	Times	Year Reviewed	MPC?
99308	Sbsq nursing facil care, low MDM	XXX	1.30	5/18/4/27	2021	No
70540	MRI Orbit/face/neck w/out dye	XXX	1.35	5/19/5/29	2016	No
74170	CT abdomen w/o & w/dye	XXX	1.40	5/18/5/28	2012	Yes
74181	MRI abdomen w/out dye	XXX	1.46	5/20/5/30	2016	No
10005	FNA bx u/s guidance	XXX	1.46	10/20/9/39	2017	No
93306	TTE w/doppler complete	XXX	1.46	3/20/5/28	2019	No
78830	RP localz tum spect w/ct 1	XXX	1.49	10/25/10/45	2019	No
99315	NF discharge 30 min or less	XXX	1.50 (current 1.28)	10/25/5/40 (current 10/20/10/40)		
99393	Pre visit est age 5-11	XXX	1.50	4.5/20/5/29.5	2010	No
99304	Initial NF stfwrld or low level MDM	XXX	1.50	6/25/5/36	2021	No
95861	Ndl EMG 2 xtr w/wo paraspinal areas	XXX	1.54	10/29/10/49	2013	Yes

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99203	Office/outpatient new low MDM 30-44 min	XXX	1.60	5/25/5/35	2019	Yes
99394	Periodic preventive med est patient 12-17 yrs	XXX	1.70	5/25/5/35	2010	No
99309	Subsq NF moderate MDM	XXX	1.92	7/30/10	2021	No

99316 Nursing facility discharge day management; more than 30 minutes

The Facilitation Committee reviewed the survey results and determined that the 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of pre-service evaluation time, 40 minutes of intra-service time and 8 minutes of post-service time.

The Committee compared 99316 to nursing facility visit code 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and noted that if 99316 was maintained at the current value of 1.90, it would cause a rank order anomaly with the previously recommended value for moderate MDM subsequent nursing facility care code 99309.

For additional support, the Facilitation Committee referenced MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 39 minutes of intra-service time) and code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes of intra-service time), which require similar physician work and time.

The Facilitation Committee agreed that 99316 compared to additional services referenced by the specialty societies in the table below supports the specialty society recommended survey 25th percentile work RVU. **The RUC recommends a work RVU of 2.50 for CPT code 99316.**

99316 Comparison Codes						
Code	Descriptor	Global	wRVU	Times	Year Reviewed	MPC?
99309	Subsq NF moderate MDM	XXX	1.92	7/30/10	2021	No
70555	FNA bx/w/ct gdn 1 st les	XXX	2.26	15/35/12/62	2017	No
75635	CT angio abdominal arteries	XXX	2.40	10/39/8/57	2016	Yes
91110	GT Tract capsule endoscopy	XXX	2.49	5/45/15/65	2016	No
99316	NF discharge more than 30 min	XXX	2.50 (current 1.90)	15/40/8/63 (current 14/25/15/54)		
99305	Initial NF moderate MDM	XXX	2.50	10/35/10/55	2021	No
95810	Polysom 6/> yrs sleep 4/> addl param attnd	XXX	2.50	15/36.5/15/66.5	2010	Yes
99204	Office/outpatient new mod MDM 45-59 min	XXX	2.60	10/40/10/60	2019	Yes
93315	Echo transesophageal	XXX	2.69	10/40/15/65	2014	No
99310	Subsqnt NF high MDM	XXX	2.80	10/45/15/70	2021	No

Practice Expense

The Facilitation Committee recommends the direct practice expense inputs adopted by the Practice Expense Subcommittee as recommended by the specialty societies without modification, be accepted.