AMA/Specialty Society RVS Update Committee
Renaissance Hotel, Chicago, IL
September 22-24, 2022

Meeting Minutes

I. Welcome and Call to Order

The RUC met in-person and virtually in September 2022. Doctor Ezequiel Silva, III called the hybrid meeting to order on Friday, September 23, 2022, at 9:00 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:
Ezequiel Silva, III, MD
Amr Abouleish, MD, MBA
Margie C. Andreae, MD
Amy Aronsky, DO
Robert Dale Blasier, MD
Audrey Chun, MD
Joseph Cleveland, MD
Scott Collins, MD
Daniel DeMarco, MD
Gregory DeMeo, DO
William Donovan, MD, MPH
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
M. Douglas Leahy, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
John H. Proctor, MD, MBA
Marc Raphaelson, MD
Richard Rausch, DPT, MBA
Kyle Richards, MD
M. Eugene Sherman, MD
Donna Sweet, MD
G. Edward Vates, MD
James C. Waldorf, MD
Thomas J. Weida, MD
Adam Weinstein, MD

RUC Alternates:
Jennifer Aloff, MD
Anita Arnold, MD
Gregory L. Barkley, MD
Eileen Brewer, MD
Leisha Eiten, AuD
Dawn Francis, MD, MHS
William Gee, MD
Martha Gray, MD
David C. Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kris Kimmell, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Sanjay A. Samy, MD
Kurt A. Schoppe, MD
James L. Shoemaker, MD
Clarice Sinn, DO
Michael J. Sutherland, MD
Mark T. Villa, MD
David Wilkinson, MD, PhD
David Yankura, MD
Robert Zwolak, MD

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II. Chair's Report

Doctor Silva introduced himself and welcomed everyone to the in-person RUC meeting. He explained the virtual component of the meeting and that virtual participants would be able to view the meeting proceedings in webinar format. Additionally, he reminded participants of RUC confidentiality provisions, general expectations for the meeting, and highlighted the importance of conference etiquette.

- Doctor Silva communicated the following guidelines related to confidentiality:
  - All RUC attendees must adhere to the confidentiality agreement that was attested to prior to the meeting.
  - Confidentiality extends to both materials and discussions at the meeting.
  - Recording devices are prohibited. However, this meeting is being recorded by the AMA.
  - The full confidentiality agreement can be found on the RUC Collaboration site (Structure and Functions).

- Doctor Silva conveyed the Lobbying Policy:
  - "Lobbying" means unsolicited communications of any kind made at any time for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees.
  - Any communication that can reasonably be interpreted as inducement, coercion, intimidation, or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.
  - Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.
  - Full lobbying policy found on Collaboration site (Structure and Functions).

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

- Doctor Silva conveyed the following information on the virtual and in-person components:
  - Virtual attendees are in listen-in-only mode.
  - All meeting registrations received the Zoom link.
  - In-person attendees may follow along on the screens in the room or the shared screen on Zoom.

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) staff (virtual):
  - Perry Alexion, MD
  - Larry Chan
  - Arkaprava Deb, MD
  - Edith Hambrick, MD
  - Zehra Hussain
  - Morgan Kitzmiller, MHA
  - Scott Lawrence
  - Ann Marshall
  - Karen Nakano, MD

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  - Julie Rauch
  - Gift Tee
  - Pamela Foxcroft Villanyi, MD
  - Pam West

- Doctor Silva welcomed the following Contractor Medical Director:
  - Janet Lawrence, MD
  - Barry Whites, MD (virtual)
  - Richard Whitten, MD (virtual)

- Doctor Silva welcomed the following observers:
  - Jake Abrahams – Health & Human Services
  - Michael Brown – Health & Human Services
  - Christian Laurence – Health & Human Services
  - Emma Watters Reardon – Health & Human Services
  - Shirin Hormozi – Office of Management and Budget
  - Daenuka Muraleetharan – Office of Management and Budget

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

- Doctor Silva announced departing RUC Members:
  - Jim Clark, MD (CAP)
  - Alan Lazaroff, MD (AGS RUC Alternate)
  - Norman Smith, MD (AUA)
  - Stanley Stead, MD (ASA)

- Doctor Silva announced the new RUC Members:
  - Amr Abouleish, MD (ASA)
  - Audrey Chun, MD (AGS)
  - Kyle Richards, MD (AUA)

- Doctor Silva commemorated two RUC members on their years of service as Chair and Vice Chair of the RUC (2015-2021):
  - Peter K. Smith, MD
  - Michael D. Bishop, MD

- Doctor Silva announced the RUC reviewer guidelines:
  - To enable more efficient RUC reviews, AMA staff shall review specialty Summary of Recommendation forms (SORs) for adherence to our general guidelines and expectations, such as:
    - Specialty representation
    - Survey methodology
    - Vignette
    - Sample size
    - Budget Neutrality / Compelling evidence
    - Professional Liability Insurance (PLI)

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- Doctor Silva shared the following procedural issues for RUC members:
    - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue, and it will be reflected in the minutes.
    - RUC members or alternates sitting at the table may not present or debate for their society.
    - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.

- Doctor Silva conveyed the following procedural guidelines related to Voting:
    - Work RVU and Direct Practice Expense Inputs = 2/3 vote
    - Motions = Majority vote
    - RUC members will vote on all tabs using the single voting link provided via email.
    - You will need to have access to a computer or smartphone to submit your vote.
    - If you are unable to vote during the meeting, please notify AMA staff.
    - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.
    - We vote on every work RVU, including facilitation reports.
    - If members are going to abstain from voting, please notify AMA staff so we may account for all 29 votes.
    - If specialty society presenters require time to deliberate, please notify the RUC Chair.
    - If RUC advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC chair or AMA staff.

- Doctor Silva stated the following procedural guidelines related to RUC Ballots:
    - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.
    - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
    - You must enter the work RVU, physician times and reference codes to support your recommendation.

- Doctor Silva shared the process for reviewing Research Subcommittee recommendations:
    - The Research Subcommittee meeting reports are always included in the Research Subcommittee folder.
    - For ease, now you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.

III. Director's Report

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

- Ms. Smith conveyed the following information regarding the Practice Expense data collection effort:
    - The AMA is working with Mathematica to initiate a new practice expense data collection effort.
    - Data would be collected and analyzed in 2023 and 2024, based on 2022 cost data
    - The AMA has met with HHS and CMS to discuss the effort.
    - Pilot studies and practice interviews were conducted in 2020 and Summer 2022.
    - Draft survey questions will be circulated to specialty societies for review (week of September 26).

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- Sample distribution by specialty will be circulated to specialty societies for review in November pending report from Mathematica.

- Ms. Smith reviewed the RUC Database application:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets
  - Download offline version, you will be prompted whenever there is an update available.
  - Be sure to clear cache and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - The database reflects 2020 data.

- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process:
  - The RUC Process webinars may be accessed via the RUC Collaboration home page or click "General Resources" from the left navigation bar and then "New to the RUC" and "RUC Process Webinars & Presentations."
  - The RUC Process webinars may also be accessed directly via the YouTube link: https://www.youtube.com/playlist?list=PLpUAhDflHfcoS89T0wxivYpHmsYl8fxZp

- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2024 and 2025 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Dec 13, 2022	Jan 11-14, 2023	Naples, FL	CPT 2024
Apr 4, 2023	Apr 26-29, 2023	San Diego, CA	CPT 2025
Aug 29, 2023	Sep 27-30, 2023	Chicago, IL	CPT 2025

- Ms. Smith provided a reminder that the AMA's CPT & RBRVS Symposium will be held virtually from November 16-18, 2022. Registration is available at the following link: ama-assn.org/cpt-symposium.

IV. Approval of Minutes from the April 2022 RUC Meeting

The RUC approved April 2022 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update

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

- Panel meeting activity in response to the COVID-19 pandemic:
  - Update on Panel's Response to SARS-CoV-2 Vaccine & Monkeypox
    - Covid Vaccine: To date, 53 CPT codes have been created to describe manufacturer-specific Covid vaccine codes. The latest release on August 31, included 8 new codes to describe the bivalent (omicron variant) boosters from both Pfizer and Moderna.

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        - Monkeypox Vaccine: AMA leadership continues to be in contact with CDC and CMS officials to determine, if necessary, new codes for intradermal administration of the JYNNEOS vaccine.

- September 2022 Panel Meeting:
    - 36 items of business
    - Notable agenda items:
        - 6 Digital medicine related CCAs
        - 11 Category III code applications
    - Preventive Care Pelvic Exam - Established code 99459 to report preventive care pelvic exam. Referred as a result of discussion at the April 2022 Relativity Assessment Workgroup (RAW) on gender equity payment between services performed by gynecologists and urologists.
    - Venography Services - Revise codes 93584, 93585, 93586, 93587, 93588 (approved for 2024 code set); rescind code 9X001 (approved for 2024 code set); and revise Cardiac Catheterization for Congenital Heart Defects guidelines and parenthetical notes
    - Unlisted Code Reporting Guidelines Revisions - Revise various sections of the CPT code set containing unlisted services codes to reflect appropriate use when reporting with other services

- CPT Ad Hoc Workgroups:
    - Lower Extremity Revascularization Discussion
        - Co-Chairs: Barbara Levy, MD; Daniel Picus, MD; Robert Piana, MD
        - Workgroup Charge: To create a Code Change Application that will address the RUC's Relatively Assessment Workgroup recommendation to address CPT code 37229 (Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed) high volume growth, through revision of the Lower Extremity Revascularization code family.
        - After internal discussion with the Panel, the Workgroup was changed to a "discussion forum" with the interested stakeholders (specialty societies and industry) at the September Panel meeting.
    - Tumor Genomics Neoplastic Targeted GSP Workgroup
        - Co-Chairs: Lawrence Simon, MD and Aaron Bossler, MD
        - Workgroup Charge: To create CPT coding solution(s) for extended/comprehensive genomic testing in tumor/neoplastic conditions, including whole genome sequencing. In the deliberation process, the workgroup will utilize information gained in the AMA's July 2021 Diagnostic Precision Medicine Coding and Payment meeting to determine the feasibility of more granular coding solutions within this space. If deemed appropriate the workgroup may additionally suggest a more granular coding solution for non-neoplastic genomics testing.
        - The Workgroup has held three public virtual meetings on June 13, July 11 and August 18 to determine an appropriate coding solution to address extended/comprehensive genomic testing in tumor/neoplastic conditions. A final public Workgroup meeting was held on the morning of Thursday, September 15. Following this meeting, a CCA will be prepared for submission at the February 2023 Panel meeting.
    - Unlisted Code Workgroup
        - Co-Chairs: Kevin Vorenkamp, MD; Tim Swan, MD; Nelly Leon-Chisen

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        - 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.
        - The Workgroup finished their work and submitted revisions to the CPT code set as part of Tab 65.
    - Appendix P-T Workgroup
        - Co-Chairs: David M. Kanter, MD, MBA and Richard A. Frank, MD, PhD
        - Workgroup Charge: To develop objective criteria for the Panel to utilize for maintenance of the list of CPT codes listed in Appendix P and if deemed appropriate the Workgroup will provide suggested edits to the Appendix P introduction guidelines. In such edits, the Workgroup should consider modification of the Appendix P title, relative to Appendix T, and relevant modification of introductory language in Appendix T, as deemed appropriate.
        - The Workgroup held three meetings and finalized recommendations for the CPT Editorial Panel Executive Committee to review at the September 2022 EC Meeting.
    - CPT/RUC Telemedicine Office Visits Workgroup
        - Co-Chairs: Chris Jagmin, MD and Peter Hollmann, MD
        - Workgroup Charge: The workgroup will assess available data and determine appropriate next steps to determine accurate coding and valuation, as needed, for E/M office visits performed via audio-visual and audio-only modalities.
        - This is a joint workgroup with five CPT members and five RUC members. The scope is limited to telemedicine office visits. The workgroup has had two planning meetings to discuss the goals of the group, determine the workplan and prepare for the first open meeting which was August 25, 2022. The workgroup members decided to send a survey to the medical specialties in order to learn how telemedicine is being used across specialties and to better understand what practice expense is incurred.

- Upcoming CPT Editorial Panel Meeting:
    - The next Panel meeting is February 2-4, 2023 (Thursday-Saturday) – La Jolla, CA
    - The next application submission deadline is November 2, 2022 (for February 2-4, 2023, meeting)

- Doctor Simon addressed questions from the attendees:
    - A RUC member clarified that the RUC referral for the Pelvic Exam CPT code was not specific to practice expense (PE) only. Doctor Simon confirmed that the CPT Editorial Panel and the applicants were aware that the referral was broad and that the applicants and the Panel agreed that it was most appropriate as a PE only code. Further discussion was held regarding the gender specific language and the typical work required to perform this service. AMA staff and RUC leadership identified the necessary steps to request revisions to the CPT descriptor and vignette. Additional clarification was provided to specify that the code is for any time a pelvic exam is done with an Evaluation & Management (E/M) or preventive medicine service.

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VI. Centers for Medicare & Medicaid Services Update

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

- On July 7, 2022, 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, 2023. The calendar year (CY) 2023 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 6, 2022. and CMS is actively working on reviewing the comments received. We thank the AMA and other interested parties for their comments.

- Topic highlights from the CY 2023 PFS NPRM:
    - CY 2023 PFS Rate-Setting/Conversion Factor
    - Evaluation and Management Services
    - Telehealth Services Under the PFS
    - Dental and Oral Health Services
    - Behavioral Health
    - Chronic Pain Management
    - Skin Substitutes

VII. Contractor Medical Director Update

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

- Multi Mac Workgroup Updates
    - At the present time there are 15 Workgroups at various stages of activity.
    - Workgroups adjust their levels of activity as needed.
    - If it is determined that a Local Coverage Determination (LCD) will be developed, that workgroup meets more frequently and regularly.
    - The workgroup meetings are in addition to the standing collaborative meetings.

- Multi Mac Workgroups (WG)
    - There are presently 15 Multi Mac workgroups and they are as follows:
        - AI
        - ALJ MAC Collaboration
        - Carrier Advisory Committee (CAC)
        - Category III code
        - Correct Drug Administration Coding (Complex Drug Article)
        - Edits
        - LCD Prioritization
        - Medical Review TPE (Formerly E&M)
        - New CMD Orientation
        - Opioid MAT LCD

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  - Ophthalmology
  - Pain Management
  - Pricing
  - Remote Physiologic Monitoring
  - Self-Administered Drugs (SAD)

- Pain Management Workgroup
  - The workgroup has created a new article concerning the appropriate use of anesthesia associated with pain management procedures (facet and other injections).
  - Use of Moderate or Deep Sedation, General Anesthesia, and Monitored Anesthesia Care (MAC) is usually unnecessary or rarely indicated for these procedures and not routinely reimbursable and therefore may be denied. In exceptional circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record individual consideration may be considered on appeal.

- Ophthalmology Workgroup
  - The ophthalmology workgroup received a complaint of improper billing of MIGS (Microinvasive Glaucoma Surgery). The contractors are looking into the complaint. It appears that there are issues around the billing, coding, and evaluation of goniometry.

- Remote Physiologic Monitoring
  - Must be reasonable and necessary to aid in the diagnosis and/or treatment of a patient's illness and/or injury.[4] The patient must have an acute or chronic condition[4] that is managed by the ordering health care provider who is eligible to bill Medicare for Evaluation/ Management (E/M) services.[4] The physiological data is non-face-to-face[5] and must help to describe the patient's health status and must be used to create a plan of treatment[2,5] for the patient (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate).[1] The use of medical devices must assist in improved health outcomes and functioning related to the treatment plan.[5] The interactive communication is in real-time, synchronous, and can be conversation or can be enhanced with video or technological applications.[2,5]

- Remote Physiologic Monitoring (RPM) Workgroup
  - The Remote Physiologic Monitoring Workgroup has met several times and is still trying to wrap its arms around guidance for the appropriate use of these technologies. The important questions to be answered are:
    - How will it guide the patient management?
    - How long should it continue (end point, goal)?
    - Who is monitoring? What specialties?
    - Very little peer reviewed literature
    - A Multijurisdictional Meeting is in the works to get clarity on the above questions

- Category III Workgroup
  - Meets as determined by the release of new T codes
  - Reviews the literature available (peer-reviewed and that provided by the manufacturer/developer)
  - Some overlap between this WG and the pricing WG

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- Pricing Workgroup
    - Meets as needed when questions or concerns arise regarding pricing (questions may come externally or from one or more of the MACs)
    - Consistently tries to reimburse based on RVUs determined from the information available for review (the more information made available to us, the more accurately we can price items or services)
    - As always especially with these codes, the more specific and complete the documentation we receive, the better we can assess what was done and compensate accurately

- Correct Drug Administration Coding Workgroup
    - Workgroup is presently inactive pending further CMS guidance

- Self-Administered Drugs Workgroup
    - Medicare Part B does generally not cover drugs that can be self-administered, such as those in pill form, or are used for self-injection.
    - Determination of "Usually Self-Administered" is a Benefit Determination.
    - If a drug is determined to be usually self-administered by a patient, then it is NOT considered a Medicare part B payable benefit.
    - Workgroup exceptions:
        - There are some statutorily created exceptions that technically have their own benefit category. Examples of self-administered drugs that are covered include:
            - blood-clotting factors
            - drugs used in immunosuppressive therapy (e.g., certain transplant patients)
            - erythropoietin for dialysis patients
            - osteoporosis drugs for certain homebound patients
            - certain oral cancer drugs
            - Drugs considered "supplies" used in DME equipment (*see Section 110.3)
        - In certain circumstances, (i.e., hospital outpatient setting) Medicare pays for drugs that may be considered usually self-administered by the patient when such drugs function as supplies.
    - 50.2 determining self-administration of drug or biological
        - Section of the MBPM that discusses CMS instruction on the determination of "usually self-administered"
        - MACs are only required to consider certain types of evidence when making the determination
        - MACs must publish these determinations on their website and providers are given 45 days notice before having to comply
        - List of "SAD" drugs found in the respective MAC's Usually Self-Administered Drug article found in the Medicare Coverage Database
    - Important clarifications:
        - SAD drugs listed in an article
        - This is NOT an LCD, therefore CACs, open meetings, and other formal LCD processes are not applicable
        - CMDs may meet and discuss with other MACs CMDs, but each MAC must make their own respective decision
        - This determination is all or nothing despite what place of service the drug is utilized (example: Emergency department use is not payable)
        - This is a benefit category determination

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- ABNs are not required
- If medication claim is denied by part B because the drug is on the "SAD" list, the beneficiary is liable but may appeal.

- References
  1. https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part
  2. https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
  3. https://telehealthresourcecenter.org/resources/fact-sheets/remote-physiologic-monitoring-rpm/
  4. 2021 Medicare Coverage of Remote Physiologic Monitoring (RPM) (aamc.org)
  5. Telehealth and remote patient monitoring | Telehealth.HHS.gov

- Doctor Lawrence addressed questions from the attendees:
  - A RUC member inquired about the CAC workgroup for increasing involvement in proposed LCD's, is there a method to ensure stakeholders concerns/feedback before identifying the proposal to increase engagement. Doctor Lawrence responded that it varies among the MACs and each engages their stakeholders differently, however, each MAC has a mechanism for soliciting stakeholder feedback. A RUC member encouraged all societies to work with their members to make sure that they are engaged with their local MACs so that they can provide their knowledge and experience with coverage issues. Doctor Lawrence also encouraged those with involvement inquiries to reach out to their individual MAC and reiterated that each MAC may not have a standing CAC, but they make a large effort to engage with physicians in the community and with specialty societies.
  - A RUC member asked if remote therapeutic monitoring (RTM) is included with remote physiological monitoring (RPM). Doctor Lawrence stated that the literature and evidence are different so they will be reviewed separately, however, she encouraged individuals or societies to submit evidence at any time outside of a scheduled meeting.
  - A member of the audience sought clarification on the comment that physician attendance at CAC's was inconsistent and mentioned that engagement was in their experience consistent. Doctor Lawrence agreed and stated that she can only speak for Noridian's experience, however, physician and specialty society engagement is highly encouraged and necessary for a collaborative process.

VIII. Washington Update

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

- Payment Updates
  - Conversion factor reduced 4.42% from $34.6062 to $33.0775 due to:
    - Expiration of 3% legislative update to offset previous budget neutrality adjustment
    - Additional 1.5% budget neutrality adjustment for 2023
    - Multiyear freeze on updates under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Projected Medicare Economic Index (MEI) (medical inflation) increase of +3.7%

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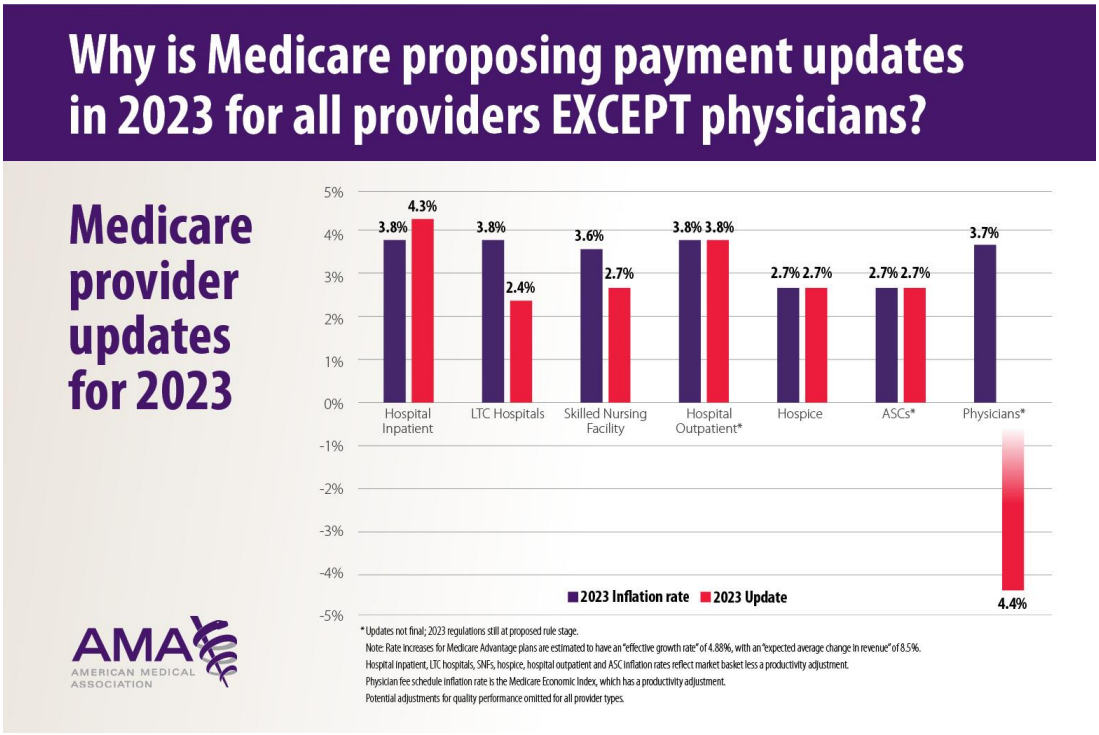
- 4% PAYGO sequester
- Need for Congressional action before the end of year to prevent cuts
- AMA comment letter



- Telehealth
  - During COVID-19 Public Health Emergency (PHE):
    - Addition of 150 services that can now be provided via telehealth, including emergency department visits, critical care, home visits, and telephone visits.
    - Created category 3 of the Medicare Telehealth List, which are codes covered through 2023 on an interim basis to allow data to be gathered to help determine whether they should become category 1 or 2
    - An additional category of services was only slated to be covered on the Medicare Telehealth List until the end of the PHE, including CPT codes for telephone visits
  - CMS proposed that, consistent with Consolidated Appropriations Act (CAA) legislation, codes that were to stop being covered via telehealth when the PHE ends will extend for an additional 151 days (five months) after the PHE ends
  - CMS did not adopt AMA recommendation to add CPT codes for telephone visits to category 3, but they will now be covered until 151 days after the PHE
  - Absent new legislation, on Day 152 after the PHE, the CPT codes for audio-only (99441-99443) will return to former "B" status.
  - CMS proposed that also on Day 152 after PHE, Medicare telehealth services be paid at the "facility" rate instead of the "non-facility" rate, as CMS believes the facility amount "best reflects the practice expenses, both direct and indirect, involved in furnishing services via telehealth"

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- AMA Telehealth Comments
    - The Social Security Administration (SSA) requires Secretary to "pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system."
    - CMS does not have authority to reduce payments to facility rate for an office-based physician
    - AMA has formed joint CPT/RUC Telemedicine Office Visits Workgroup to assess available data and ascertain appropriate next steps to determine accurate coding and valuation, as needed, for office visits performed via audio-visual and audio-only modalities
    - AMA urged CMS to keep current payment policies in place at least until this workgroup has an opportunity to ensure appropriate coding and valuation of visits performed via telehealth

- Revising MEI & Practice Expense Data Collection
    - In the nearly 50 years since MEI's creation, data collected by AMA has served as consistent source of info for weighting physician work, practice expense and PLI components
    - CMS proposes updating MEI weights by using Census Bureau data that was never designed for this purpose
    - Proposal would shift weight from physician work and Practice Liability Insurance (PLI) to practice expense and largely help facilities such as Independent Diagnostic Testing Facilities (IDTFs) and portable x-ray suppliers; many physician specialties would face cuts
    - Proposal would also lead to significant geographic redistribution
    - AMA is engaged in effort to collect practice cost data and urged CMS to pause consideration of other data sources for MEI until this effort is completed

- E/M Visits and Inclusion in Global Surgery
    - CMS generally proposed adopting revised CPT E/M Guidelines and RUC-recommended values for inpatient and observation, emergency department, nursing facility and home visits, and discharge day management and cognitive impairment assessment
    - AMA urged CMS to include office visit, hospital visit and discharge day management relative value increases in the global surgical packages
    - AMA stated concern about CMS assumptions regarding non-provision of visits in global surgical packages and urges CMS to rely on RUC's Relativity Assessment Workgroup to identify any misvaluation of global services
    - CPT/RUC Workgroup on E/M will meet to discuss possible changes to prolonged services, multiple same-day visits, and split (or shared) visits

- Medicare Payment for Dental Services
    - CMS proposed Part A payment for inpatient hospital services connected with dental services when patient's underlying medical condition, clinical status or severity of dental procedure requires hospitalization
    - AMA supported CMS' clarification of its policies and asked CMS to share full list of dental services rendered in connection with Part A procedures and seek public comment
    - CMS sought comments on dental services inextricably linked to clinical success of certain Part A services

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  - AMA comments opposed paying for dental services under physician payment schedule and raise concerns about budget neutrality
  - AMA recommended CMS do a demonstration project to explore how to pay dentists for the services associated with a limited set of Part A procedures

- Medicare Shared Savings Program
  - AMA supported proposal to create more appropriate glide path to financial risk by allowing Accountable Care Organizations (ACOs) up to 7 years in upside-only tracks
  - AMA supported proposal for advance payments to ACOs but recommended it be expanded to all ACOs with underserved beneficiaries
  - Comments recommended that existing ACOs be able to opt into improved financial methodology, so it does not just apply to new ACOs
  - AMA supported extending incentives for eCQM reporting through 2024
  - AMA suggested improvements to proposed ACO health equity adjustment

- Advanced Alternative Payment Models (APM)
  - 2022 is last "performance year" for 5% Advanced APM incentive payment
  - Administration should encourage Congress to extend it for 6 years and give CMS authority to set revenue thresholds so physicians can qualify
  - Physicians incur significant costs from APM participation; it will be difficult for them to participate without the 5% incentive payments
  - CMS should work to provide all physicians with opportunities to voluntarily participate in well-designed APMs
  - AMA has concerns about CMS proposal to permanently establish nominal risk at 8% and urges CMS at a minimum to lower risk requirements for small and rural practices participating in APMs

- Merit-Based Incentive Payment System (MIPS)
  - AMA is alarmed by CMS estimates that 1/3 of MIPS clinicians will be penalized in 2025 based on 2023 proposals
  - AMA urged CMS to lower 2023 performance threshold
  - CMS should apply Extreme and Uncontrollable Circumstances hardship exception for 2022 performance period, and conduct outreach to help practices resume MIPS participation without undue burden or expense
  - 2022 is last performance period of $500 million funding for those achieving exceptional performance threshold –CMS should support its extension

- MIPS Value Pathway (MVP)
  - 5 new MVPs proposed and 7 previously proposed MVPs are revised
  - Cost of MIPS reporting produces reverse Robin Hood effect favoring large systems – MVPs are opportunity to fix this, but currently MVPs mostly involve same requirements as existing MIPS in new packaging
  - Subgroup reporting optional for MVPs in 2023 but required for multispecialty groups in MVPs starting in 2026
  - In response to MVP Request for Information (RFI), AMA recommended:
    - CMS work with specialties to develop patient-centered MVPs instead of so much focus on individual metrics
    - Reduce required number of MVP metrics and incentivize participation
    - Payment flexibility needed to address needs of low-income patients and Social Determinants of Health (SDOH)

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        - Provide timely and actionable claims data analysis

- AMA Recovery Plan for America's Physicians
    - Support telehealth to maintain coverage and payment
    - Stop scope creep that threatens patient safety
    - Fix prior authorization to reduce the burden on practices and minimize care delays for patients
    - Reduce physician burnout and address the stigma around mental health
    - Reform Medicare payment to promote thriving physician practices and innovation
    - https://www.ama-assn.org/amaone/ama-recovery-plan-america-s-physicians

- Prior Authorization
    - On September 14, 2022, the House passed, by voice vote, the "The Improving Seniors' Timely Access to Care Act of 2022" (H.R. 8487)
    - Specifically, the bill would:
        - Require Medicare Advantage (MA) plans to implement electronic prior-authorization programs that adhere to newly developed federal standards, as well as establish real-time decision-making processes for items and services that are identified as "routinely approved"
        - Mandate that MA plans issue accelerated prior authorization decisions for all other services in Medicare Part C
        - Enhance transparency by requiring MA plans to report to CMS on the extent of their use of prior authorization and the rate of approvals and denials
    - Focus now turns the Senate where companion legislation, sponsored by Sens. Marshall (R-KS), Sinema (D-AZ), Thune (R-SD) and Brown (D-OH), has 41 cosponsors (21D, 22R)

- Telehealth
    - The House of Representatives passed H.R. 4040, Advancing Telehealth Beyond COVID-19 Act of 2022 (Cheney-Dingell) on July 27 by a vote of 416 to 12. It now moves to the Senate for approval.
    - The AMA applauded passage of the bill, which provides a clean, two-year extension of important telehealth policies enacted at the start of the COVID-19 pandemic through the end of 2024. This includes provisions to:
        - Lift the rural-only and the originating site limitations for two years
        - Remove in-person requirements for telemental health for two years
    - Working with the Connected Health Initiative, of which the AMA is a steering committee member, and the Alliance for Connected Care, along with more than 400 other organizations to encourage Senate action this year.

- Medicare: AMA approach to reaching consensus
    - Workgroup of state and specialty societies organized Fall 2021
        - Issues identified, options proposed, research conducted
    - Principles document titled "Characteristics of a Rational Medicare Physician Payment System" developed and subsequently endorsed by 120 state medical societies and national specialty societies
    - Policy recommendations refined for major financial issues
        - Annual payment updates
        - Budget neutrality calculations
    - Smaller workgroup developing a new framework to replace MIPS

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  - Agreement reached on common 2022 end-of-year advocacy agenda
  - https://www.ama-assn.org/practice-management/medicare-medicaid/current-medicare-payment-system-unsustainable-path

- 2022 end-of-year Medicare advocacy agenda
  - Avert 4.42% cut
  - Inflationary update
  - Waive 4% PAYGO sequester
  - Pass the Value in Health Care Act
    - Extend the expiring 5% bonus for advanced APM participation
    - Extend lower threshold of 50% for advanced APM participation (vs. 75%)

- Bipartisan bill to avert 4.42% cut
  - Supporting Medicare Providers Act of 2022 introduced by Reps. Bera and Bucshon in the House would avert 4.42% budget neutrality cut in 2023
  - "An imminent 4.42% physician payment cut as we emerge from a global pandemic will have a devasting impact on access and care for Medicare beneficiaries. Moving forward with this cut now is wrongheaded and inconceivable. Yet this is what is scheduled to take place. The AMA commends Reps. Bera and Bucshon for acknowledging the disparity between what it costs to run a physician practice and what these cuts will mean for patient care in the Medicare program. Our patients are counting on Congress to agree to a solution, and the clock is ticking," said Dr. Jack Resneck Jr, President of the American Medical Association.

- Ms. Hananoki addressed questions from the attendees:
  - A RUC member made a statement about the AMA efforts, "I would like to really thank you for your presentation, and I'm not just referring to the Medicare update work. I don't think any physicians in this country fully appreciate the work of people like you and the AMA staff in general, on representing us in these crucial times. To tie this with Dr. Silva's opening remark, and Ms. Smith's comments about the new Practice Expense survey effort, I think anybody in this room has a choice of whether they belong to the AMA or not, but I, for one, have been a member for a long time, and am greatly appreciative, appreciative of all the efforts to represent the physician community and all the work you do. So, I'd just like to say thank you to you and all the AMA staff for these efforts in these trying times. Thank you."
  - A RUC member stated that the 5% advance payment model (APM) incentive and related ACO structure has been very successful for their large group-based practice. The RUC member further stated that the success is attributed to engagement between specialties and helps their practice move toward a more value based system and that the AMA efforts in this area are greatly appreciated.
  - A RUC member reviewed the types of medical procedures that require dental procedures beforehand and suggested that the AMA consider recommending that those dental services be considered part of Medicare Part A funds rather than the MFS. Ms. Hananoki confirmed that the AMA requested further clarification on when the dental services should be considered part of Medicare Part A or Part B.
  - A RUC member inquired further about the request from CMS for comments on which dental services should be covered and pointed out that there are scenarios in which the applicable services could have overlap with procedures performed by oral surgeons. Ms. Hananoki confirmed that the AMA received input from both the American Dental

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Association (ADA) and oral surgeons during the comment drafting process but will continue to address this potential issue as conversations are ongoing.
- A meeting attendee thanked the AMA for raising the issue of inflationary updates in the MFS. In response, Ms. Hananoki stated that the AMA has highlighted how long physician payment has failed to keep up with inflation to both Congress and CMS.

Medicare Physician Spending Growth and Telehealth Use for 2021

Kurt Gillis, PhD, Principal Economist, American Medical Association, provided the report on Medicare physician spending growth and telehealth use for 2021.

- Overview
  - Focus on Medicare Physician Payment Schedule (MFS) services
  - Track broad measures of MFS spending and utilization from 2019 to 2021
  - Track telehealth spending and use from 2020 to 2021
  - Key questions:
    - Has Medicare physician spending returned to pre-pandemic levels?
    - How has use of telehealth changed during the pandemic?

- Data
  - Using claims for a 5% sample of Medicare beneficiaries
  - Files are available quarterly from CMS
  - Totals are extrapolated to the full Part B fee-for-service population

- Changes in spending reflect a variety of factors
  - COVID-19
  - Changes in pay
    - The 3.75% CF increase for 2021
    - Redistribution of pay with changes to RBRVS for 2020 and 2021
  - "Trend" changes in utilization
    - Faster growth for some services and specialties
  - Changes in enrollment
    - 2.5% decrease in fee-for-service enrollment for 2020
    - 4.4% decrease for 2021 (nearly 7.0% decrease from 2019 to 2021)

- Part B FFS Enrollment, 2019-2021 (in millions)
  - From 2019 to 2021, the Part B FFS enrollment significantly decreased from ~33 million to less than ~31 million.
  - *Please see attached presentation for graphics.*

- MFS Spending by Quarter Relative to 2019-Q4
  - MFS spending dropped sharply in the second quarter of 2020 and then began to recover, however, by the end of 2021 spending is about 4% below what it was prior to the pandemic.
  - *Please see attached presentation for graphics.*

- MFS Spending Per Enrollee Relative to 2019-Q4
  - Given the decrease in enrollment, the per enrollee spending by the end of 2021 is 3% above what it was prior to the pandemic.
  - *Please see attached presentation for graphics.*

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- Percent of Enrollees with an MFS Service (Persons Served) by Quarter
    - The percentage of Medicare enrollees that received a physician service in a given quarter dropped in 2020 and recovered just under pre-pandemic levels by the end of 2021 (approximately three quarters of enrollees were getting a physician service in the last quarter of 2021).
    - *Please see attached presentation for graphics.*

- Did overall MFS spending recover to pre-pandemic levels in 2021?
    - No –if the measure is total spending
    - Yes –if the measure is spending per enrollee
    - And –broad measures of MPFS utilization were not quite back to pre-pandemic levels at the end of 2021

- MFS Spending by Type of Service
    - The four major types of service categories in the MFS: E/M, imaging, procedures, and tests fluctuated as expected. E/M recovered relative to 2019 Q4 data toward the end of Q4 2021. The other three are still below where they were prior to the pandemic by anywhere from 8-11%.
    - *Please see attached presentation for graphics.*

- Change in annual MFS Spending from 2019 to 2021 by Specialty
    - The change in spending by specialty from 2019 to 2021 varies greatly. For example, spending is down across the majority of specialties ranging from 3-15%, although a few specialties have an increase in spending that ranges from 2-16%.
    - *Please see attached presentation for graphics*.

- Telehealth
    - Telehealth is defined as:
        - CPT/HCPCS codes on CMS' telehealth list (including those added during the pandemic) AND
        - Billed with a telehealth modifier or place of service
    - Examine spending overall and by service category

- Telehealth Spending as Share of MFS Total (Jan 2020 – Dec 2021)
    - Telehealth spending spiked to over 16% of the MFS total in the second quarter of 2020, although it has been declining ever since with spikes correlating to increases in COVID cases and/or restrictions.
    - *Please see attached presentation for graphics.*

- Percent of Beneficiaries with Telehealth Service (by Quarter)
    - The percent of Medicare enrollees that had a telehealth service in given quarter spiked (~29%) in the second quarter of 2020 as expected, and then fell sharply over the following quarters with ~11% of enrollees getting a telehealth service by the end of 2021.
    - *Please see attached presentation for graphics.*

- Most of the $3.4 Billion in MFS Telehealth Spending for 2021 was Concentrated in a Few Service Categories
    - We continue to see concentrated spending for telehealth services specific to just a handful of categories with the largest share represented by established patient office visits. The second highest is attributed to mental health services.

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- *Please see attached presentation for graphics.*

- Share of Frequency Provided as Telehealth
  - Mental health services are the top telehealth category with over 50% of services being provided by telehealth in 2020 compared to just over 39% in the fourth quarter of 2021. Established patient office visits is the second top telehealth category with over 24% of services being provided by telehealth in the second quarter of 2020 compared to just over 6% at the end of 2021.
  - *Please see attached presentation for graphics.*

- Telehealth Spending as a Share of MFS Total for 2021 (Select Specialties)
  - This chart shows specialties that had above-average telehealth spending
  - Clinical social workers had the highest telehealth spending share at 53%, followed by clinical psychologists at 42% and psychiatrists at 37%
  - *Please see attached presentation for graphics.*

- Summary
  - Overall MFS spending was still below the pre-pandemic level at the end of 2021
    - But this was due (in part) to a decline in FFS enrollment
    - On a per-enrollee basis, MFS spending had recovered to pre-pandemic level in 2021
  - Telehealth use has declined gradually since the early months of the pandemic
    - Use continues to be concentrated in a handful of service categories
    - Use for Mental Health Services remained at a relatively high level through the end of 2021

- Dr. Gillis addressed questions from attendees:
  - A RUC member inquired about the shift in the MFS beneficiaries to Medicare Advantage (MA) plans and how that may impact the Medicare data, hypothesizing that sicker patients may on average be more likely to stay in fee-for-service and less sick patients on average may more often switch toward MA plans. The member further inquired about how the AMA is responding to the shift in Medicare fee-for-service data. Dr. Gillis responded that if the hypothesis were to be true, we would see faster utilization growth in the fee for service portion of the program, but we will monitor that trend.
  - A RUC member followed on the question regarding a shift from Medicare fee-for-service to Medicare Advantage plans and the ways that the RUC relies on this data. The member further inquired whether the AMA might have access to Medicare Advantage data. Dr. Gillis responded that we would explore this data and the potential shift.
  - A RUC member inquired about payment to Physicians Assistants and Nurse Practitioners and how that data is reflected by independent primary care vs other employment. Dr. Gillis responded that there is not a way to break out those categories via the claims data, but he will explore other sources to see if the requested breakout is possible.
  - A RUC member commented on the need for data related to Medicare Advantage copays as patients shift from fee-for-service to Medicare Advantage plans.
  - A meeting attendee supported the inquiries made regarding the need for more granular data related to Medicare Advantage plans.

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IX. Relative Value Recommendations for CPT 2024

Spinal Neurostimulator Services (Tab 4)
Damean Freas, MD (NANS), Michael Lubrano, MD (ASIPP), Eric Kano Mayer, MD (NANS), Carlo Milani, MD (AAPM&R), Gregory Polston, MD (AAPM), John Ratliff, MD (AANS), Richard Rosenquist, MD (ASA), Clemens Schirmer, MD, PhD (CNS) and Graham Wagner, MD (SIS)

In October 2020, the RUC identified CPT code 63685 via the high-volume growth screen with Medicare utilization of 10,000 or more that increased by at least 100% from 2014 through 2019. The Relativity Assessment Workgroup (RAW) requested that the specialty societies submit an action plan for each code identified for January 2021. In January 2021, the RUC recommended referring code 63685 to CPT Assistant.

In February 2022, the CPT Editorial Panel revised four Category I codes and created three new Category I codes; the Panel also created six new Category III codes and revised four Category III codes. The revision of the four existing Category I codes included updates to the introductory guidelines, descriptors, and parentheticals for implantation, revision, and removal of spinal (63685 and 63688) and peripheral nerve (64590 and 64595) neurostimulator pulse generator or receiver devices. The three new Category I codes 64596, 64597 and 64598 are specifically for an integrated neurostimulator for the peripheral nerve (except for sacral, as integrated neurostimulators for the sacral nerve are instead described by new category III codes 0786T and 0787T). CPT codes 64596, 64597 and 64598 include a parenthetical referring integrated neurostimulator services for bladder dysfunction procedures to instead use a Category III code, as well, and therefore, would not be relevant to patients with bladder dysfunction. Instead, CPT Category III codes 0587T and 0588T were created for the percutaneous implantation, revision, replacement, and removal of an integrated single device neurostimulation system for bladder dysfunction. The dominant specialty societies performing the spinal neurostimulator services appealed CPT codes 63685, 63688, 64596, 64597, and 64598 at the May 2022 CPT Editorial Panel meeting. The appeal was rejected and CPT codes 63685, 63688, 64596, 64597, and 64598 were surveyed for the September 2022 RUC meeting.

63685 ***Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver***
The RUC reviewed the survey results from 102 physicians including spine surgeons and determined that the current work RVU of 5.19, which is below the survey 25th work RVU, appropriately accounts for the work required to perform this service. The RUC recommends 33 minutes pre-service evaluation, 12 minutes positioning, 13 minutes scrub/dress/wait time, 50 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99213 post-operative office visit, equaling 170 minutes total time.

The specialty societies recommended, and the RUC agreed, that pre-service time package 3-*FAC straightforward patient/difficult procedure* was appropriate with times as follows:

Evaluation time – Standard package time of 33 minutes is recommended which is significantly less than the survey median of 45 minutes.

Positioning time – The survey median time of 12 minutes is recommended. The additional 9 minutes above the time package accounts for supine positioning for anesthesia line placement followed by prone positioning with padding to protect neurovascular structures. This

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additional time is analogous to the standard additional positioning times included for posterior spinal procedures and injections.
Scrub/dress/wait time – The median time of 13 minutes is recommended which reduces the package by 2 minutes to match the survey time.

Moreover, the RUC noted that this survey replicated the findings of the previous survey for CPT code 63685. The survey times from 2008 were 45/15/11 minutes (evaluation/ positioning/ scrub/dress/wait) pre-service time which closely aligns with the 2022 survey pre-times of 45/12/13.

The RUC discussed both the increase in pre-service time and the decrease in intra-service time. While the intra-service time from the current survey is 10 minutes less than the prior survey intra-time, the survey pre-service time is 10 minutes greater than the current listed time. The 2008 RUC recommended pre-service times were not in fact derived from the 2008 survey itself and were instead reduced later by the RUC, likely inspired by RUC's pre-service time packages which were only starting to be implemented at that same 2008 RUC meeting. The total time has not changed from the prior survey (i.e., work per unit time (WPUT) has not changed). In addition, the intensity has increased due to the evolution of the technology. Since an increased number of devices and multiple manufacturers are now present compared to 2010, compatibility of equipment must be confirmed. The current standard of practice is to test each of the previously placed leads separately for impedances to verify secure connection and proper function. This adds complexity to the procedure which is accounted for by a slightly higher intensity. Moreover, the patient often has had multiple surgeries and failed other treatments, therefore, the work involved is more intense and complex. The RUC also commented on the initial insertion versus replacement and noted that there would be scarring, and other complexities involved with the replacement, including ensuring that the electrodes are compatible with the battery as well as ensuring the electrodes are not damaged, which modify the intensity of the surveyed code.

The RUC compared CPT code 63685 to the top key reference service MPC code 62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming* (work RVU = 5.60, 60 minutes intra-service time and 170 minutes total time) and noted that both codes describe implantation of a device and have the same total time; however, the MPC code requires more intra-service time related to the placement of a subcutaneous pump in the abdomen for drug infusion and therefore is appropriately valued higher. The RUC also compared the surveyed code to the second highest key reference service code 62360 *Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir* (work RVU = 4.33, 60 minutes intra-service time and 170 minutes total time) and noted that, although the total time is the same, the surveyed code describes placement of a neurostimulator generator in the lower back area above the iliac crest and below the 12th rib using fluoroscopy, which adds to the complexity of code 63685 which is twice as intense as the reference code and therefore is appropriately valued higher. The current work RVU maintains appropriate rank order with the key reference codes.

For additional support, the RUC compared CPT code 63685 to MPC code 64561 *Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed* (work RVU = 5.44, 45 minutes intra-service time and 131 minutes total time) and noted that the comparator code has less intra-service and total time compared to the surveyed code but is more intense. To bracket the code, the RUC also compared CPT code 63685 to MPC code 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm* (work RVU = 4.00, 45 minutes intra-service time and 85 minutes total time) and noted that the comparator code describes complex closure requiring more than layered closure, while code

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63685 includes both exposure/creation of a pocket for the generator and layered closure over the device with care taken in placing the generator above the iliac crest and below the 12th rib to avoid irritation of the generator against either of these structures.

The RUC concluded that the value of CPT code 63685 should be maintained at 5.19, below the survey 25th percentile. **The RUC recommends a work RVU of 5.19 for CPT code 63685.**

63688 ***Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array***

The RUC reviewed the survey results from 99 physicians including spine surgeons and determined that the survey 25th percentile work RVU of 4.35 appropriately accounts for the work involved in this service. The RUC recommends 33 minutes pre-service evaluation, 10 minutes positioning, 12 minutes scrub/dress/wait time, 45 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99213 post-operative office visit, equaling 162 minutes.

The RUC agreed with the specialty societies' recommendation for pre-service time package 3-*FAC straightforward patient/difficult procedure* with adjusted pre-service positioning and pre-service scrub, dress, and wait times to match the survey median times of 10 minutes and 12 minutes, respectively. The additional 7 minutes above the time package for positioning time accounts for supine positioning for anesthesia line placement followed by prone positioning with padding to protect neurovascular structures. The RUC noted that this survey replicated the findings of the previous survey for CPT code 63688. The survey times from 2008 were 40/15/10 minutes (evaluation/ positioning/ scrub/dress/wait) pre-service time which closely aligns with the 2022 survey pre-times of 45/10/12.

The RUC compared CPT code 63688 to the top key reference service code 62365 *Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion* (work RVU = 3.93, 45 minutes intra-service time and 155 minutes total time) and noted that both codes describe removal of a device and have the same intra-service time; however, the surveyed code requires more total time and is more intense and therefore is appropriately valued higher. The RUC also compared the surveyed code to the second highest key reference service MPC code 62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming* (work RVU = 5.60, 60 minutes intra-service time and 170 minutes total time) and noted that the MPC code has more intra-service and total time and is more intense as it involves the placement of a subcutaneous pump in the abdomen for drug infusion and therefore is appropriately valued higher than the surveyed code. The RUC noted that the two key reference services appropriately bracket the surveyed code.

For additional support, the RUC compared CPT code 63688 to MPC code 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm* (work RVU = 4.00, 45 minutes intra-service time and 85 minutes total time) and noted that the comparator code describes complex closure requiring more than layered closure, while code 63688 involves removal of the generator above the iliac crest and below the 12th rib which involves a similar amount of physician work. The RUC concluded that CPT code 63688 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 4.35 for CPT code 63688.**

64596 ***Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; initial electrode array***

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64597 ***Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; each additional electrode array (List separately in addition to primary procedure)***
64598 ***Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator***

The specialty societies submitted a letter to request that CPT codes 64596, 64597, and 64598 be contractor priced. Despite their best efforts – survey requests were sent to a random sample of 7,165 members then an additional random sample of 1,200 – the societies were unable to meet the survey minimum threshold of 30 responses. Amongst the limited number of responses received, 30-50 percent did not have experience with the service. In instances of low survey responses, the RUC has determined that it should not automatically recommend contractor pricing but continue its current process and review each unique code set individually. Based on discussion of the survey results, the RUC concurred that another survey attempt would not garner a sufficient number of experienced responses. **The RUC recommends that CPT codes 64596, 64597, and 64598 be contractor-priced until such time that utilization has increased and more experience with these services is acquired.**

Relativity Assessment Workgroup (RAW) Review
When Category I services have survey responses below 30, the RUC procedure is to flag these services to be reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code. **The RUC recommends that CPT codes 64596, 64597, and 64598 be re-reviewed in three years by the Relativity Assessment Workgroup to determine whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.**

New Technology/New Service
The RUC recommends that CPT codes 64596, 64597, and 64598 be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made one modification to switch the pack from SA054 *pack, post-op incision care (suture)* to SA052 *pack, post-op incision care (staple)* which reflects typical practice of using staples to close the incision. **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.

<u>Intraoperative Ultrasound Services (Tab 5)</u>
Richard Fine, MD (ASBS), Richard Freeman, MD, MBA (STS), Stephen Lahey, MD (AATS), Jim Levett, MD (STS), Charles Mabry, MD (ACS), Donald Selzer, MD (ACS), Walton Taylor, MD (ASBrS), Edward Touhy, MD (ACC), Joseph Turek, MD (STS), Prashanth Vallabhajosyula, MD (STS), Thad Waites, MD (ACC) and Richard Wright, MD (ACC)

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In October 2018, the Relativity Assessment Workgroup (RAW) created a screen for CMS/Other codes with Medicare utilization of 20,000 or more, and CPT code 76998 was subsequently identified as part of that screen. CPT code 76998 was not surveyed during the Harvard study and has never been reviewed by the RUC or by CMS. When CPT code 76998 was identified in the CMS/Other screen, it was noted that many specialties were represented in the Medicare claims data, and hence, specialties representing cardiothoracic surgery, general surgery, breast surgery, urology, interventional cardiology, interventional radiology and vascular surgery jointly submitted an action plan that the RAW reviewed in October 2019.The action plan submitted to the RAW noted that the use of code 76998 by general surgeons likely represented reporting by several subspecialists (eg, breast, vascular, oncology). Based on the variability of intraoperative ultrasound for each specialty with differences in the typical patient and physician work, it was decided that each society would submit applications for new code(s) as needed to carve out the work currently reported with 76998 until the code was no longer needed or until it was clear what the final dominant use of 76998 was so that a survey could be conducted.

In October 2019, the RUC referred this issue to the CPT Editorial Panel to clarify correct coding and accurately differentiate physician work as multiple specialties currently report CPT code 76998. Several areas of reporting code 76998 were addressed by the Panel in 2020 and 2021, including: addition of instructional parentheticals that restrict the use of imaging guidance with vein ablation procedures, addition of new codes that bundled imaging guidance for urological procedures; and a Panel determination about correct coding for intraoperative intra-abdominal diagnostic ultrasound. In May 2022, the CPT Editorial Panel created four new codes to report intraoperative cardiac ultrasound services. This action carved out most of the prior reporting of code 76998 by cardiothoracic surgeons and cardiologists.

After utilization was removed from code 76998 for vein ablation procedures, most urological procedures, cardiac procedures and intra-abdominal procedures through instructions and/or new or revised codes, it was determined that the dominant use of the code would be related to breast surgery, allowing for code 76998 to be surveyed. CPT codes 76984, 76987, 76988, 76989, and 76998 were surveyed by the specialties for the September 2022 RUC meeting.

76984 ***Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic***
The RUC reviewed the survey results from 44 cardiothoracic surgeons and cardiologists and determined that the survey 25th percentile work RVU of 0.60, appropriately accounts for the typical physician work required to perform this service. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service time and 3 minutes post-service time as supported by the survey. The specialties noted that CPT code 76984 describes ultrasound performed in the operating room through an open chest where the ultrasound probe is placed directly on the thoracic aorta. The specialties noted that this intraoperative ultrasound service is performed because a transesophageal echocardiogram (TEE) could not fully visualize the thoracic aorta due to air in the trachea or there are contra-indications to TEE during surgery such as previous esophagectomy, achalasia or stenosis. This service examines the desired cannulation or grafting sites to determine if plaque or calcium is present. The pre-service time accounts for the cardiothoracic surgeon securing the ultrasound equipment, supplies and determining the settings. The intraoperative time incudes the cardiothoracic surgeon placing the ultrasound probe directly on the thoracic aorta obtaining targeted images of the aorta to determine if plaque and/or calcium is present and if so, decide on alternative cannulation strategies and/or grafting sites. The immediate post time includes storing the final images as appropriate and generating a separate report of the findings within the operative note.

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To justify the 25th percentile work value of 0.60, the RUC compared the surveyed code to MPC code 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU= 0.60, intra-service time of 10 minutes, total time of 16 minutes) and noted that both services typically involve an identical amount of intra-service times and an analogous amount of physician work. The RUC also compared the surveyed code to 2nd key reference code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography* (work RVUs= 0.92, intra-service time of 15 minutes, total time of 25 minutes) and noted that the reference code involves 5 more minutes of intra-service time and 7 more minutes of total time, justifying a somewhat lower value for the reference code. The RUC concluded that CPT code 76984 should be valued at the 25th percentile work RVU as supported by the survey and comparison to other similar services. **The RUC recommends a work RVU of 0.60 for CPT code 76984.**

76987 ***Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report***

The RUC reviewed the survey results from 31 cardiothoracic surgeons and determined that the survey 25th percentile work RVU of 1.90, appropriately accounts for the typical physician work required to perform this service. The RUC recommends 10 minutes pre-service time, 20 minutes intra-service time and 10 minutes post-service time as supported by the survey. The specialties noted that CPT code 76987 is rarely used and describes ultrasound image acquisition performed in the operating room through an open chest where the ultrasound probe is placed directly on the patient's beating heart, and hence due to the low volume and the cardiothoracic surgeon's infrequent performance of the procedure, a very intense and complex service to perform. This service would typically be performed on infants and is only for patients with congenital defects and where transesophageal echocardiogram (TEE) is contraindicated. However, the patient could have still received a transthoracic echocardiogram (TTE) and other imaging before receiving this service. It was noted that intraoperative epicardial cardiac ultrasound services are expected to be very rare, as intra-operative TEE is considered the gold standard and can be performed for most patients instead. The specialties noted that the pre-time includes intraoperative review of previous imaging immediately prior to the ultrasound and it also includes intra-operative pre-service work such as positioning of the heart, removal of packing and infusion of fluids prior to performing the ultrasound. It was also noted that the intraoperative ultrasound image acquisition would typically be performed at two different points of the skin-to-skin time (prior to and after the cardiac repair is completed) of the major surgical procedure. The immediate post-service time includes the cardiothoracic surgeon storing the final images as appropriate and generating a separate report on image acquisition, the findings and intraoperative decisions made from interpretation of multiple images of different structures of the heart before and after the cardiac repair.

For the congenital cardiac epicardial echocardiography codes (76987, 76988, 76989), it is common for a cardiologist to provide a portion of the procedure. For this reason, the congenital cardiac codes were developed to allow for one provider (typically the cardiothoracic surgeon) to perform all aspects of the intraoperative ultrasound (image acquisition and interpretation/report - 76987) and two codes (76988 and 76989) when the work is split out between two providers including a cardiothoracic surgeon and a cardiologist.

To justify the 25th percentile work value of 1.90, the RUC compared the surveyed code to MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU= 1.74, intra-service time of 22 minutes, total time of 32 minutes) and noted that although the surveyed code involves 2 minutes less of intra-service time, it involves 8 more minutes of total

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time and involves a similar intensity of physician work. Therefore, the work value of 1.90 for the surveyed code has appropriate relativity with this reference code. The RUC also compared the surveyed code to CPT code 78431 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan* (work RVU= 1.90, intra-service time of 21 minutes, total time of 39 minutes) and noted that the reference code has one more minute of intra-service time, whereas the surveyed code involves one more minute of total time. Both services involve an analogous amount of physician work. The RUC concluded that CPT code 76987 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.90 for CPT code 76987.**

76988 ***Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only***
The RUC reviewed the survey results from 33 cardiothoracic surgeons and cardiologists and determined that the survey 25th percentile work RVU of 1.20, appropriately accounts for the typical physician work required to perform this service. The RUC recommends 10 minutes pre-service time, 20 minutes intra-service time and 5 minutes post-service time as supported by the survey. The specialties noted that CPT code 76988 describes ultrasound image acquisition performed in the operating room through an open chest where the ultrasound probe is placed directly on the patient's beating heart, and due to the low volume and the cardiothoracic surgeon's unfamiliarity utilizing the ultrasound and being directed on transducer probe placement and manipulation by the cardiologist, a very intense and complex service to perform. This service would typically be performed on infants and is only for patients with congenital defects and where transesophageal echocardiogram (TEE) is contraindicated. However, the patient could have still received a transthoracic echocardiogram (TTE) before receiving this service. The specialties noted that the pre-time includes intraoperative review of previous imaging immediately prior to both ultrasounds and it also includes intra-operative pre-service work such as positioning of the heart, removal of packing and infusion of fluids prior to performing the ultrasound. CPT code 76988 includes the work of manipulating the transducer probe on the beating heart and image acquisition at the direction of the cardiologist only, and the work of interpretation and report would be performed by a separate physician (typically a cardiologist) that would be reporting 76989. It was also noted that the intraoperative ultrasound image acquisition would typically be performed at two different points of the skin-to-skin time (prior and after the cardiac repair is completed) of the concurrent major surgical procedure, such as before the surgery for planning purposes and after the surgery to assess outcomes and the need for further intervention. The work included in the immediate post-service time accounts for the cardiothoracic surgeon generating a separate report on the intraoperative discussion of the findings with the cardiologist from multiple images from different structures of the heart from both pre- and post-surgical images and if any alterations were made to the surgical plan or any additional repairs were required based on the intraoperative findings.

For the congenital cardiac epicardial echocardiography codes (76987, 76988, 76989), it is not uncommon for a cardiologist to provide a portion of the procedure. For this reason, the congenital cardiac codes were developed to allow for one provider (typically the cardiothoracic surgeon) to perform all aspects of the intraoperative ultrasound (76987) and two codes (76988 and 76989) when the work is split out between two providers including a cardiothoracic surgeon and a cardiologist. It was noted that the typical physician work in aggregate for 76988 and 76989 is greater than 76987 alone, as when 76988 and 76989 are reported, it would be two separate physicians performing the cumulative work with both physicians in the operating room performing different aspects of the work prior to the cardiac repair and again after the cardiac

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repair has been completed. During the intraoperative image acquisition portion before and after the cardiac repair, the cardiologist is in the OR with the cardiothoracic surgeon directing the surgeon on manipulating the probe to capture images of multiple structures of the heart. . Additionally, the cardiothoracic surgeon is discussing the findings real-time in the OR during the operation with the cardiologist making decisions on if the surgical plan needs to be altered or additional repairs are required based on the findings.

To justify the 25th percentile work value of 1.20, the RUC compared the surveyed code to MPC code 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU= 1.28, intra-service time of 15 minutes, total time of 25 minutes) and noted that the surveyed code involves 5 more minutes of intra-service time of 10 more minutes of total time. 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, total time of 30 minutes) and noted that the surveyed code typically involves 5 more minutes of total time. The RUC concluded that CPT code 76988 should be valued at the 25th percentile work RVU as supported by the survey and comparison to other similar services. **The RUC recommends a work RVU of 1.20 for CPT code 76988.**

76989 ***Intraoperative epicardial cardiac (eg, echocardiography) ultrasound for congenital heart disease, diagnostic; interpretation and report only***

The RUC reviewed the survey results from 31 cardiothoracic surgeons and cardiologists and determined that the survey 25th percentile work RVU of 1.55, appropriately accounts for the typical physician work required to perform this service. The RUC recommends 5 minutes pre-service time, 20 minutes intra-service time and 10 minutes post-service time as supported by the survey. This service is for the work of the cardiologist's interpretation and report only. However, the specialties noted that the cardiologist is typically in the operating room intraoperatively, prior to and after the cardiac repair with the cardiothoracic surgeon directing the surgeon on manipulating the probe to capture multiple images of different structures of the heart, interpreting the images in real-time in the operating room, and discussing the findings with the cardiothoracic surgeon to decide if the surgical plan needs to be altered or if additional procedures or repairs are necessary and then archives the images and generates the final report which would be reported with code 76989. The specialty societies noted that some of the survey respondents may have overlooked this typical work that is not separately reported. The RUC recognized this may have been the case since the cardiologist is in the OR prior to the cardiac repair and then comes back again after the cardiac repair is completed and both sets of images including multiple images of different structures of the heart are interpreted and discussed real-time in the OR with the cardiothoracic surgeon and as such, the RUC is recommending, and the specialty societies agree, that the 75th percentile of intraservice time instead of the median intraservice time be used for this code. The pre-time includes the cardiologist reviewing the procedure and reviewing prior imaging. The immediate post-service work includes the cardiologist storing the final images as appropriate and generating a separate report on the intraoperative interpretation of multiple images of different structures of the heart before and after the cardiac repair, their discussion of the findings with the cardiothoracic surgeon and any intraoperative decisions made to alter the surgical plan or if additional repairs were required based on the findings.

For the congenital cardiac epicardial echocardiography codes (76987, 76988, 76989), it is not uncommon for a cardiologist to provide a portion of the procedure. For this reason, the congenital cardiac codes were developed to allow for one provider (typically the cardiothoracic surgeon) to perform all aspects of the intraoperative ultrasound (76987) and two codes (76988 and 76989)

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when the work is split out between two providers including a cardiothoracic surgeon and a cardiologist. It was noted that the typical physician work in aggregate for 76988 and 76989 is greater than 76987 alone, as when 76988 and 76989 are reported, it would be two separate physicians performing the work and the cardiologist and cardiothoracic surgeon would be working together with both physicians in the operating room performing different aspects of the work prior to the cardiac repair and again after the cardiac repair has been completed. During the intraoperative image acquisition portion before and after the cardiac repair, as stated above, the cardiologist is in the OR helping to direct the cardiothoracic surgeon on image acquisition, interpreting the images real-time and discussing the findings with the cardiothoracic surgeon for images acquired before and after the cardiac repair.

To justify the 25th percentile RVU of 1.55, the RUC compared the surveyed code to CPT code 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, intra-service of 15 minutes, total 30 minutes) and noted that the surveyed code involves 5 more minutes of intra-service and total time. The RUC also compared the surveyed code to CPT code 78492 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)* (work RVU= 1.80, intra-service time of 20 minutes, total time of 38 minutes) and noted that both services involve an identical amount of intra-service time and similar total times. The RUC concluded that CPT code 76989 should be valued at the 25th percentile work RVU as supported by the survey and comparison to other similar services. **The RUC recommends a work RVU of 1.55 for CPT code 76989.**

76998 ***Ultrasonic guidance, intraoperative***

The RUC reviewed the survey results from 115 breast surgeons, general surgeons and surgical oncologists and determined that the survey median and current work RVU of 1.20 appropriately accounts for the typical physician work required to perform this service. The RUC recommends 5 minutes pre-service time, 12 minutes intra-service time and 5 minutes post-service time as supported by the survey. The specialties noted that additional preservice work and time is required that is independent of the operative procedure. Specifically, prior to sterile draping of the patient (included in the work of the operative procedure), the surgeon will perform a test ultrasound of the patient's breast to adjust the gain, depth of penetration, and intensity settings of the ultrasound unit that will be used for intraoperative ultrasound guidance. This preoperative ultrasound testing is performed to ensure that the ultrasound can detect and localize the abnormal breast lesion(s). The RUC agreed that 5 minutes of pre-time was justified for this work that is not separately reportable and not included in the primary procedures. Intraoperatively, ultrasound is used first to outline the margins of the mass. Then, periodically, the surgeon uses ultrasound to: (1) identify the mass and the margins as well as the surrounding normal tissue; and (2) guide additional incisions, dissection and excisions until clear margins are obtained. Intraoperative permanent images are interpreted and captured throughout the procedure This is a dynamic procedure because the surgical field and lesion of interest is changing between images. The specialty societies and RUC discussed the median intraoperative time of 12 minutes from the survey and observed that the survey respondents may have underestimated their typical time to perform the ultrasound service. Postoperatively, the surgeon will review and sign the intraoperative guidance report and additionally discuss intraoperative ultrasound findings and review the images with the patient, specifically with respect to the interpretation of clean margins. The RUC agreed that 5 minutes of post-time was justified for this work that is not separately reportable and not included in the operative procedure.

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Although the CPT code 76998 long descriptor was not revised by the CPT Editorial Panel for CPT 2024, with the creation of 76984-76987 as well as other prior new/revised CPT coding, guidelines and/or parenthetical changes over the past few years, relatively few specialties are anticipated to continue to report CPT code 76998 going forward. The specialties noted to the RUC that CPT coding changes have either already removed or anticipated to remove utilization for cardiac procedures, vein ablation procedures, most urological procedures and intraabdominal procedures. Therefore, the specialties noted that 76998 is anticipated to have general surgeons and surgical oncologists as the dominant specialties going forward and the updated typical patient for 76998 now describes a patient undergoing a partial mastectomy (ie, lumpectomy) for malignant neoplasm of the breast. The survey for CPT code 76998 was only completed by breast surgeons and general surgeons whom self-identify as surgical oncologists. The RUC noted that CPT code 76998 was reported with partial mastectomy CPT code 19301 14% of the time for Medicare patients in 2020. However, only 7% of claims for code 19301 additional reported intraoperative ultrasound in 2020.

The RUC observed that the proposed survey times represent a decrease from the CMS/Other times included in the RUC database and the current CMS time file. The RUC noted that CPT/HCPCS codes with a *CMS/Other* data source, means that this service was not surveyed in the Harvard Study and has never been reviewed by the RUC or CMS. Instead, the assigned times were input by CMS 30 years ago at the inception of the RBRVS using an unknown methodology and therefore are not valid for relative comparison to the current survey or to other codes. .

To justify a work RVU of 1.20, the RUC compared the surveyed code to the key reference code 76641 *Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete* (work RVU= 0.73, intra-service time of 12 minutes, total time of 22 minutes). The RUC noted that code 76641 describes a diagnostic ultrasound study that is typically performed by a technician, where the saved images are then reviewed and an interpretation report is generated by a radiologist at a later time. In comparison, for surveyed code 76998, a surgeon uses an ultrasound probe periodically during the operation and interprets the images in real time to help direct the limits of surgical excision of a mass. Images are saved and a report is generated by the surgeon. The specialties noted, and the RUC agreed that the intensity and complexity of code 76998 (dynamic real-time ultrasound at operation) is significantly greater than code 76641. In addition, the RUC noted that code 76641 represents a single US session typically performed by a technician, whereas code 76998 includes multiple separate US maneuvers throughout an operative procedure by the surgeon, which require a more intense immediate interpretation in order to direct resection of the breast tissue to ensure a thorough and complete surgical excision of the abnormal breast tissue. The RUC agreed that this service does not make the operation easier, but instead helps to prevent repeat operations.

As additional support, the RUC compared the surveyed code to MPC code 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU= 1.28, intra-service time of 15 minutes, total time of 25 minutes) and noted that although the reference code has slightly more intra-service and total time, the surveyed code is a dynamic service that is more intense as it is performed intraoperatively during a major surgical procedure. The RUC also compared the surveyed code to CPT code 70544 *Magnetic resonance angiography, head; without contrast material(s)* (work RVU= 1.20, intra-service time of 12 minutes, total time of 22 minutes) and noted that both services involve identical times and an analogous amount of physician work. The RUC concluded that CPT code 76998 should be valued at the median work RVU as supported by the survey and comparison to other similar services. **The RUC recommends a work RVU of 1.20 for CPT code 76998.**

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Practice Expense
The RUC recommends no direct practice expense inputs for CPT codes 76984-76989 and 76998 as they are facility-only services.

New Technology/New Services
CPT codes 76984-76989 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population and utilization assumptions.

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

Post Operative Low Level Laser Therapy (Tab 6)

In May 2022, the CPT Editorial Panel created CPT code 97037 to describe the application of low-level laser therapy for post operative pain reduction. **The RUC will not offer a recommendation on CPT code 97037 as no specialty society expressed an interest in surveying and/or developing a recommendation to the RUC.**

New Technology/New Service
The RUC recommends that CPT code 97037 be placed on the New Technology list to review when utilization is available, identifying who is performing the service

X. CMS Request/Relativity Assessment Identified Codes

Ultrasound Guidance for Vascular Access (Tab 7)
Curtis Anderson, MD (SIR), Marlin Wayne Casey, MD (SVS), Minhajuddin Khaja, MD (SIR), Andrew Moriarity, MD (ACR), Lauren Nicola, MD (ACR) and Matthew Sideman, MD (SVS)

In September 2017, the CPT Editorial Panel revised CPT codes 36568, 36569 and 36584 and created two new codes 36572 and 36573 to specify the insertion of a peripherally inserted central venous catheter (PICC), without a subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion. This coding revision created a new bundled code and incorporated a bimodal clinical scenario, wherein a clinical staff member performs the procedure without imaging, or a radiologist performs the procedure with imaging guidance. In January 2018 when this code family was surveyed, CPT code 76937 was identified as part of this family of services. CPT code 76937 is used by a variety of specialties for a variety of similar endovascular procedures, and the utilization was expected to decrease once the PICC procedures were bundled with the imaging modalities. At the January 2018 RUC meeting, the specialty societies that perform this service proposed to review CPT code 76937 when two years of Medicare data (post-PICC bundling) became available. This would allow the specialty societies to develop a typical vignette and determine which specialties would need to be involved in the survey and valuation process. CPT code 76937 was surveyed for the September 2022 RUC meeting.

Compelling Evidence
The RUC disagreed with the specialty societies that there is compelling evidence to support a change in physician work for CPT code 76937 based on a change in patient population due to the bundling of PICC line procedures (CPT codes 36568, 36569, 36572, 36573 and 36584). In their summary of recommendation, the specialty societies noted that bundling the other codes in this

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family leaves the use of this code, 76937, for more complex patients requiring central venous access in addition to the increased intensity of arterial access, including radial artery access and pedal artery access. The specialty societies believed that the removal of a large volume code family, which represented the least intense ultrasound guided vascular access procedures, creates a change in the patient population shifted towards more intense and complicated procedure types. The RUC disagreed with this assertion and cited that the removal of the PICC family of codes did not constitute a significant enough change in the patient population for 76937. The PICC family utilization is approximately 15% of the utilization of 76937. **The RUC disagrees with the compelling evidence presented that the physician work for this service has changed due to a change in the patient population.**

76937 ***Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 389 vascular surgeons, diagnostic radiologists, and interventional radiologists and recommends maintaining the current work RVU of 0.30 for CPT code 76937, which is below the survey 25th percentile of 0.50 work RVUs. The RUC recommends the survey median 10 minutes of intra-service and total time for this service.

The RUC recommends zero minutes for pre- and post-service time, as this is the standard approach for codes with a ZZZ global period. The current RUC data for 76937 includes 4 minutes of post-service time, however the societies' request to the Research Subcommittee to allow post service time on the survey was denied. The specialty societies explained that CPT code 76937 currently includes 4 minutes of post-service time for the physician to *"Review and sign guidance report. Communicate results to referring physician as appropriate."* The RUC determined that the work associated with documenting the imaging in the report is part of the documentation of the procedure and the 4 minute decrease in total time was an artifact of using a disparate ZZZ RUC survey instrument when this survey was performed 20 years ago. The RUC concluded the current work RVU valuation of 0.30 should be maintained based on the breadth and intensity of physician work involved with this service when compared against other similar codes in the MFS. The survey for 76937 performed in 2003 also only included 19 survey respondents, which does not meet modern RUC and CMS standards. Unlike the latest RUC survey, the previous ZZZ survey template used included pre-service and post-service time fields. The current standards assume the minutes spent related to reviewing the images were included in the procedure report. The RUC agrees with the specialty societies that the overall actual time for this service has NOT changed. The work relative value for this service should remain the same at 0.30.

To justify a value of 0.30, the RUC compared the surveyed code to the first key reference code 10006 *Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU=1.00, intra-service time and total time of 15 minutes) and noted that the surveyed code involves much less physician work and less physician time to perform. The RUC also compared the surveyed code to the second key reference MPC 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, intra-service time of 15 minutes and total time of 17 minutes) and noted that the surveyed code involves less time and slightly less physician work to perform. For additional support, the RUC also compared the surveyed code to MPC code 95885 *Needle*

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electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure) (work RVU= 0.35, intra-service time and total time of 15 minutes) and noted that the surveyed code involves less physician work and less physician time to perform than MPC code 95885 but is still an appropriate comparison in terms of physician work and intensity. The work RVU recommendation assigns this service a physician work intensity that is below both key reference services and the MPC code comparison but is appropriately valued based on magnitude estimation. **The RUC recommends a work RVU of 0.30 for CPT code 76937.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee agreed with the specialty societies' recommendation to change the clinical labor type from L041B *Radiologic Technologist* to L041A *Angio Technician* as the angio technician typically performs the various clinical activities related to the ultrasound for vascular access and is involved in the primary procedure. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

<u>General Behavioral Health Integration Care Management (Tab 8)</u>
Megan Adamson, MD (AAFP), Brad Fox, MD (AAFP), Charles Hamori, MD (ACP) and Elizabeth Volpert, DNP, APRN (ANA)

CPT code 99484 *Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team* was created in 2018 and placed on the on the New Technology/New Services list. In April 2022, the Relativity Assessment Workgroup reviewed three years of available Medicare claims data (2018, 2019 and 2020). The specialty societies indicated, and the RUC agreed, that this service should be surveyed for September 2022.

Compelling Evidence
The current value for CPT code 99484 is a CMS/Other source, which reflects a value CMS independently assigned to G0507 *Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team*, based on a crosswalk to code 99490 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month*. Code G0507 no longer exists, and the crosswalk to the prior value and times of CPT 99490 are no longer effective. Thus, the

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current value is not based on RUC survey data, a RUC-recommended crosswalk, or any other RUC methodology that the specialties can identify. Thus, the specialty societies indicated, and the RUC agreed, that there is compelling evidence that CPT code 99484 is currently based on flawed methodology.

99484 ***Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP***
The RUC reviewed the survey results from 63 physicians and nurse practitioners and determined that the survey 25th percentile work RVU of 0.85 appropriately accounts for the work required to perform this service. The RUC recommends 21 minutes of intra-service time for CPT code 99484. The physician/qualified healthcare professional (QHP) provides general supervision of care management services for behavioral health conditions, which are generally provided by clinical staff. In addition, the physician/QHP: reviews the results of mental health screening tools administered by the clinical staff; evaluates patient complaints, social determinants of health, or other issues impacting the patient and reviews options or prepares more options for patient; evaluates medication side effects and communicates with clinical staff about dosing or medication changes, refills, and follow-ups; consults other specialists, as needed; and reviews clinical staff notes regarding family members' input and talks directly to family members, caregivers, or the patient, as needed. The physician/QHP manages and/or supervises the provision of services, as needed, for psychosocial needs and activities of daily living for the patient.

The RUC compared the surveyed code to the top two key reference services, 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 CPT code 99490 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month* (work RVU = 1.00 and 25 minutes intra-service and total time). The RUC indicated that the surveyed service requires less physician time and work than these two key reference services. The RUC noted that CPT codes 99484 and 99490 require similar intensity and complexity to perform, however, the reference code requires more work since the physician/QHP is managing multiple chronic conditions in which the patient is at significant risk of death, acute exacerbation/decompensation, or functional decline.

For additional support, the RUC compared CPT code 99484 to MPC code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 20 minutes total time) and 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time), which require similar physician work and time. The RUC concluded that CPT code 99484 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.85 for CPT code 99484.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs for CPT code 99484 and agreed with the specialty societies to remove clinical activity CA011 *Provide*

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education/obtain consent and supply item SK114 *tissue (Kleenex)*. The RUC questioned which clinical labor type typically performs CA021 *Perform procedure/service---NOT directly related to physician work time* and the specialty societies indicated that the typical clinical labor staff is not L057B *Behavioral Health Care Manager* but L037D *RN/LPN/MTA*. Thus, the RUC recommends a change to the clinical staff type. **The RUC recommends the direct practice expense inputs as modified.**

Transitional Care Management Services (Tab 9)
Michael Polston, MD (AGS), Korinne Van Keuren, DNP, RN (ANA) and Elisabeth Volpert, DNP, APRN (ANA)

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. In September 2021, the Administrative 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 acknowledged 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 recommended and the RUC agreed to flag these services as "Do not use to validate physician work" in the RUC database. The RUC agreed and placed 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 TCM services were on an LOI after the October 2021 RUC meeting and the specialties indicated they would survey for the April 2022 RUC meeting. However, at the April 2022 RUC meeting the specialty societies requested deferral to survey until the September 2022 RUC meeting. This request was based on the societies desire to know whether CMS was going to make any proposals that would negate the need to affirm the valuation for the TCM codes. The specialty societies also noted that they originally intended to survey the TCM services so that they would be able to use them on reference service lists when surveying other services. However, after further examination the societies indicated that the inpatient hospital visit codes may be available soon for use on reference service lists instead. After the Proposed Rule is published, the specialty societies indicated they would examine if the current services available fill the gaps for codes to populate reference service lists and whether the TCM codes need to be surveyed. The RUC agreed to postpone the survey of the TCM services until the September 2022, RUC meeting.

In September 2022, the specialty societies withdrew their option to survey the TCM services. The specialty societies indicated that in the Proposed Rule for CY 2023, CMS generally accepted the RUC recommendations for inpatient services, nursing home and prolonged services, which adds

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more services that will be available for use in reference service lists or as comparators, eliminating the current need to survey TCM.

The RUC accepted the specialty societies withdrawal to survey CPT code 99495 and 99496. The RUC recommends that the current flag of "Do not use to validate physician work" be maintained in the RUC database.

During this discussion a RUC member questioned the claims reported with TCM services. Based on the quarterly 5% carrier files for 2021, TCM services are NOT typically reported by the same physician reporting the discharge management. Only 6% of TCM services (CPT codes 99495 and 99496) were reported by the same NPI as the matching discharge (CPT codes 99238 and 99239). This is down from the 2016 data, in which 14% of TCM services were reported by the same NPI as the matching discharge service.

XI. Research Subcommittee

The Research Subcommittee did not have a general policy meeting which coincided with the September 2022 RUC meeting. The Subcommittee had last met on June 6, 2022, to review specialty society requests pertaining to RUC surveys for the September meeting. On the June 6th call, the Research Subcommittee reviewed and approved proposed vignettes, reference service lists, custom survey templates and a targeted survey sample methodology.

XII. Practice Expense Liability Insurance (PLI) Workgroup- (Tab 11)

Doctor Gregory DeMeo, Chair, provided the report of the Professional Liability Insurance (PLI) Workgroup. Instead of an in-person meeting, the Workgroup held their meeting via conference call on August 3, 2022, to align with the CY 2023 Medicare Physician Payment Schedule Proposed Rule comment period.

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 inputs 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 CY2023, 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. The PLI Workgroup reviewed the updated proposed list of low specialty overrides for eligible services. The proposed list included 64 newly added services. The specialties had concurred with the initial proposed override for 63 of the 64 services. The Workgroup updated code 99319 from cardiac

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electrophysiology to cardiology, noting that general cardiologists would instead be the typical specialty for this service.

The PLI Workgroup approved the proposed list of Expected Specialty Recommendations for Low Volume Codes for CY2023 NPRM Comment (as included in tab 11 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 2023. The draft PLI section of the letter offered input below on four key areas of the PLI methodology in the Proposed Rule: 1) *Improvements in Data Collection: Non-Physician Health Care Professional and Other Non-Physician Medicare Specialty Premium Rates; 2) PLI RVU Specialty Mix Policy and Technical Corrections for Codes with Professional Component/ Technical Component Split; 3) Imputation Methodology; 4) Low Volume Service Single-specialty Overrides.* The Workgroup agreed that the draft content prepared by AMA RUC Staff was appropriate and did not have any suggested changes.

The RUC approved the Professional Liability Insurance Workgroup Report.

XIII. Practice Expense Subcommittee (Tab 12)

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

The RUC determined in April 2022 that the PE Subcommittee should further review the issue of dermal adhesives, specifically Dermabond, at its September meeting after accepting the use of SG007 *adhesive, skin (Dermabond)* as part of Tab 7 Neurostimulator Services-Bladder Dysfunction.

The staff note for discussion at the September meeting included a list of 38 codes that contained one of the four supply codes with "adhesive" in the supply description. The Subcommittee discussed that Dermabond is not typically used and is only included in four G codes. The Subcommittee raised further questions on adhesive alternatives and the price of $57.67 for Dermabond compared to the generic version. Members also questioned why a brand name was specified. **The RUC agreed that a PE Workgroup should be created to review adhesives broadly (skin, wound, dressing) and potentially identify general principles for their use.** Interest was also expressed in finding a systematic way to review the supply item list for brand names and to provide the generic alternatives. AMA Staff will check with CMS to see if they prefer the brand names and/or can provide insight into the use of brand names versus generic.

Sherry Smith also provided an update on the Practice Expense Data Collection effort by the AMA. **The RUC approved the Practice Expense Subcommittee Report.**

XIV. Relativity Assessment Workgroup (Tab 13)

Doctor Proctor provided the Relativity Assessment Workgroup report to the RUC.

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Use of 2020 Medicare Claims Data
Some RUC members and staff inquired about the Relativity Assessment Workgroup's use of the 2020 Medicare claims data due to that being the first year of the COVID-19 pandemic. The Workgroup noted that 2020 Medicare Physician Payment Schedule spending was 14% lower than expected, due principally to the pandemic effect. Applying 2020 utilization may not appropriately identify codes in certain RAW screens. The Workgroup reviewed each screen that will use 2020 Medicare data and determined that this only effects the High Volume Growth screen when the 2020 Medicare data is the base year of data being examined and the CPT Assistant Analysis review. **The Workgroup recommends that when the High Volume Growth screen is run in 2027, that the Workgroup review the 2020-2026 data and make determinations on the 2020 data at that time.** For the CPT Assistant article on the Autonomic Function Testing codes (95921-95924) that was published in September 2020. **Since these services were also flagged for re-review in October 2023, the Workgroup recommends delaying review of the impact review of the CPT Assistant article on Autonomic Function Testing codes and to review the 2021 data in October 2023 along with the specialty mix.**

Re-review of Services – Review Action Plans

Site of Service Anomaly
Tissue Grafting Procedures (15769)
The 2020 Medicare utilization data shows that CPT code 15769 is performed in the inpatient hospital setting 39% of the time, yet includes one hospital discharge visit 99238. The Workgroup noted that 20% of these services are being reported in the office setting by only four individuals. **The Workgroup recommends that a CPT Assistant article be created to clarify that CPT code 15769 should be reported in the facility setting.**

Codes Reported Together 75% or More
Vertebral Corpectomy with Arthrodesis (22558 & 63090)
The Workgroup reviewed the current data and agreed with the specialty societies that the CPT guidelines changes and continuing coding education for CPT codes 22558 and 63090 have been successful. No further review is needed.

RUC Flag for Re-review
PICC Line Procedures (36568, 36569, 36572, 36573 & 36584)
The PICC line bundling of codes resolved the issue of concern before the RUC previously. The Workgroup agreed with the specialty societies that for CPT code 36569, the Medicare utilization is appropriate and this service is being reported by expected specialties. No further review is needed.

Review Action Plans

CMS/Other Source
The Workgroup identified six codes with 2020 Medicare utilization data over 20,000. Codes 95851, G0105, G0121, G0425, G2010 and G2012. **The Workgroup reviewed action plans and recommended the following:**

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Code	Recommendation
95851	Maintain and notify CMS of possible misreporting by one individual in Texas (based on the Medicare Physician & Other Practitioners by Provider and Services 2020 Medicare data).
G0105	Maintain. CPT codes exist and these G codes were created by CMS to administer the colorectal cancer screening benefit.
G0121	Maintain. CPT codes exist and these G codes were created by CMS to administer the colorectal cancer screening benefit.
G0425	**Survey for January 2023.**
G2010	Refer to CPT to review by the CPT/RUC Telemedicine Office Visits Workgroup.
G2012	Refer to CPT to review by the CPT/RUC Telemedicine Office Visits Workgroup.

High Volume Growth – 2015-2020

The Workgroup identified ten codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020. **The Workgroup reviewed action plans and recommends the following:**

Code	Recommendation
11046	Review after 2 years of data available (2021-2022 data) after variation due to the pandemic stabilizes.
64488	Maintain, utilization is appropriate, consistent with best practices and reflects the recent downward trend of opioid prescriptions for pain management post-surgery.
65778	**Survey CPT 65778, 65779, and 65780 for January 2023 RUC meeting.**
75571	Maintain, growth is as expected. Additionally, new CPT guidelines were recently revised that may be driving some utilization.
78580	Review after 2 years of data available (2021-2022 data) after variation due to the pandemic stabilizes.
88381	Review after 3 years after additional data available (2021, 2022 & 2023 data).
G0277	**Review PE at January 2023 RUC Meeting.**
G0442	Survey for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.
G0444	Survey for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.
G0446	Survey for April 2023.

Surveyed by one specialty and now performed by a different specialty

The Workgroup identified two codes, 27369 and 99457, 2020 with 2020 Medicare utilization over 10,000 where a service was performed by one specialty but is now performed by a different specialty. **The Workgroup reviewed the action plans and recommended that CPT code 27369 be reviewed in 2 years to allow education on miscoding take effect and that CPT code 99457 be reviewed in 2 years (2021-2022 data) after utilization has stabilized after the pandemic. The Workgroup noted that acupuncture codes 97810, 97811, 97813 and 97814 were identified on this screen but were not listed on the RAW review at this meeting in error. The Workgroup will review an action plan for these services at the January 2023 meeting.**

Category III Codes with High Volume

The Workgroup identified five Category III codes with 2020 Medicare utilization over 1,000. **The Workgroup reviewed action plans and recommends the following:**

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Code	Recommendation
0042T	Specialty societies indicated and the Workgroup supports submission of a coding application for CPT May 2023.
0054T	Review in 2 years after additional claims data available (2021-2022 data).
0055T	Review in 2 years after additional claims data available (2021-2022 data).
0232T	Review in 2 years after additional claims data available (2021-2022 data).
0507T	Review in 3 years to see if this service meets CPT criteria for a Category I code.

CPT Assistant Analysis

The Workgroup identified two issues which the RUC referred to CPT Assistant and an article was published in 2019. The Workgroup reviewed action plans for 95983, 95984, 95976, 95977 and 75898.

The Workgroup noted that CPT code 75898 was identified via the codes reported together screen and the specialties are recommending for a code bundling solution for CPT 2025. **The Workgroup agreed CPT code 75898 will be addressed with a code bundling solution. For codes 95976-95984, the specialties indicated and the Workgroup agreed that the CPT Assistant article addressed initial concerns on when to report simple versus complex cranial nerve neurostimulator services.**

Contractor Priced High Volume

The Workgroup identified six codes that are contractor priced with 2020 Medicare utilization over 10,000**. The Workgroup reviewed action plans and recommends the following:**

Code	Recommendation
90868	Maintain contractor priced.
95700	Utilization was much lower than expected. Review after 2 years of data available (2021-2022 data) after variation due to the pandemic stabilizes.
95715	Utilization was much lower than expected. Review after 2 years of data available (2021-2022 data) after variation due to the pandemic stabilizes.
G0399	CPT codes 95800, 95801 and 95806 exist and may replace these G codes**. Request again, that CMS delete in the RUC recommendations letter.**
G2066	Request that the RUC reaffirm its 2018 approved PE inputs for 93299 and recommend that they be utilized to establish national pricing for G2066. However, 93299 was deleted in 2022. Code G2066 will be placed on the LOI for January 2023 for the RUC to make any formal RUC recommendations.
G6017	Maintaining the components of the RO-APM is critical. Maintain the inputs for all the codes in the radiation treatment delivery family and remove from RAW screens.

Services Performed Together 75% or More

The Workgroup identified 19 code pairs for services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in 2020 Medicare claims data and/or contained at least one ZZZ global service were removed. **The Workgroup reviewed action plans and recommends the following:**

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Code1	Code2	Recommendation
22554 63082	63081 22554	Refer to CPT Assistant to educate correct coding for 22554 with 63081 versus bundled codes 22551 and 22552.
26480	25447	Refer to CPT 2025 for a code bundling solution.
29828	29827	Maintain. Code bundling not necessary and already subject to MPPR.
51728	51741	Refer to CPT Assistant to educate providers about the coding and use of complex uroflowmetry. Some providers may believe that 51741 is part of the "pressure-flow" study of 51728 or 51729, but it is not. CPT code 51741 should only be reported if done separately from urodynamic studies, on a separate machine and only when medically necessary/indicated.
51728	51784	Refer to CPT Assistant to educate how EMG studies should only be used selectively and when medically necessary.
51729	51741	Refer to CPT Assistant to educate providers about the coding and use of complex uroflowmetry.
51729	51784	Refer to CPT Assistant to educate how EMG studies should only be used selectively and when medically necessary.
55700	76872	Refer to CPT for revision of code descriptors and/or introductory language to clarify when to and when not to report CPT code 76872 (ultrasound, transrectal) as a diagnostic procedure when performed at the same time as CPT code 55700 (prostate biopsy).
61624	75894	Refer to CPT 2025 for a code bundling solution.
61624	75898	Refer to CPT 2025 for a code bundling solution.
64415	76942	Codes were bundled for 2023.
64447	76942	Codes were bundled for 2023.
67028	92134	Remove 67028 from screen, these are separate and distinct services.
70496	70498	Refer to CPT 2025 for a code bundling solution.
70547	70544	Review in 2 years (2021-2022 data) after practice patterns in the inpatient and outpatient setting go back to how it was prior to the pandemic. (Note: 2019 reported together data was 66%).
93890	93886	Refer to CPT 2025 for a code bundling solution.
93890	93892	Refer to CPT 2025 for a code bundling solution.
93892	93886	Refer to CPT 2025 for a code bundling solution.
93892	93890	Refer to CPT 2025 for a code bundling solution.

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

The RUC approved the Relativity Assessment Workgroup Report.

XV. Health Care Professionals Advisory Committee (HCPAC) (Tab 14)

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

The HCPAC Review Board reviewed the following Relative Value Recommendations for CPT 2024:

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Caregiver Training Services (Tab 14)
Randy Boldt, PT, MPT (APTA), Katie Jordan, OTD, OTR/L, FAOTA (AOTA), Dee Adams Nikjeh, PhD, CCC-SLP (ASHA)

In May 2022, the CPT Editorial Panel created three Category I codes, 97550, 97551, and 97552 to report skilled training of caregiver strategies and techniques to facilitate functional performance and safety without the patient present, in addition to guidelines for caregiver training without the patient present. All three new codes are currently not reported by any existing CPT codes. For the September 2022 RUC HCPAC Review Board meeting, CPT codes 97550-97552 were reviewed.

The purpose of this code family is to maximize the patient's function while working toward improved clinical outcomes related to the primary diagnoses and treatment plan. These codes allow for reporting the physician/QHP work and/or time associated with the caregiver training, which is performed in tandem with the diagnostic and intervention services rendered directly to the "identified patient" that support the patient's optimal level of function. There is ample evidence supporting the efficacy and effectiveness of direct intervention with the caregiver(s) of children, adolescents, and adults to improve symptoms, functioning, adherence to treatment, and/or general welfare related to the patient's primary clinical diagnoses.

97550 ***Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes***
The HCPAC reviewed the survey results from 95 occupational therapists, physical therapists, and speech language pathologists for CPT code 97550 and recommends a work RVU of 1.00, which reflects the survey median RVU and appropriately accounts for the work required to perform this service with the caregiver, without the patient present. The HCPAC recommends 5 minutes of pre-evaluation time, 30 minutes intra-service time, and 5 minutes immediate post-service time.

For this service, the qualified health care professional (QHP) provides skilled intervention as part of a therapy plan of care to introduce strategies and techniques to the caregiver to assist the patient living with functional deficits to competently guide completion of daily life activities. The completion of daily life activities may include patient safety instruction; identification and implementation of compensatory strategies for proper sequencing, following directions, and safe activity completion; graded interventions focusing on motor, process, communication, and other skills that affect functional activity performance; problem solving approaches to adapt to unusual tasks; environmental adaptation training; use of individualized visual or verbal cueing, memory devices (e.g., picture lists), sequenced directions, or other approaches to enable completion of activities; or training in the use of equipment or assistive devices for self-care/home management. Caregiver understanding and competence in implementing these skilled interventions is critical for patients with functional limitations resulting from conditions including, but not limited to, stroke, traumatic brain injury (TBI), various forms of dementia, or autism spectrum disorders.

To support the recommended work RVU, the HCPAC compared the surveyed code to key reference service codes 97535 *Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one*

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contact, each 15 minutes (work RVU = 0.45, 15 minutes intra-service time, 21.5 minutes total time) and 96170 *Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes* (work RVU = 1.50, 30 minutes intra-service time, 45 minutes total time). The surveyed code falls appropriately between these key references services when compared to the work RVU, total time, and related intensity of each service. The surveyed code is appropriately valued at the survey median work RVU of 1.00 and maintains relativity within the code family and MFS. For additional support, the HCPAC referenced CPT code 92584 *Electrocochleography* (work RVU = 1.00, 30 minutes intra-service time, 45 minutes total time), which requires identical work and similar time. **The HCPAC recommends a work RVU of 1.00 for CPT code 97550.**

97551 ***Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550)***

The HCPAC reviewed the survey results from 87 occupational therapists, physical therapists, and speech language pathologists for CPT code 97551 and recommends a work RVU of 0.54, which reflects the survey 25th percentile RVU and appropriately accounts for the work required to perform this service with the caregiver, without the patient present. The HCPAC recommends 17 minutes intra-service time for this add-on code. The specialty societies stated, and the HCPAC agreed, that the survey median time of 17 minutes appropriately accounted for the time and work spent providing skilled interventions to caregivers. Further, 17 minutes is in the appropriate range of intra-service time required to report a 15-minute add-on code (8-22 minutes). Typically, the specialties and HCPAC agreed, that CPT code 97551 is likely to be commonly reported with the 30 minutes base code, 97550, but no more than once.

For this add-on service, the qualified health care professional (QHP) provides skilled intervention beyond the initial 30 minutes of time as part of a therapy plan of care to introduce strategies and techniques to the caregiver to assist the patient living with functional deficits to competently guide completion of daily life activities. The QHP continues to provide approaches to enable completion of activities or training in use of equipment or assistive devices for self-care/home management of the patient in accordance with the treatment plan as needed. The work required to perform this add-on service is increasingly complex as the interventions often become more difficult to demonstrate and tailor as needed for the caregiver.

To support the recommended work RVU, the HCPAC compared the surveyed code to key reference service codes 96171 *Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.54, 15 minutes intra-service and total time) and 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48, 15 minutes intra-service and total time). The surveyed code is appropriately supported by the key reference services when compared to the similar intensity and slightly higher total time of the surveyed code. The surveyed code is appropriately valued at the

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survey 25th percentile work RVU of 0.54 and maintains relativity within the code family and MFS. For additional support, the HCPAC referenced MPC code 96168 *Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.55, 15 minutes intra-service and total time) which requires similar work and total time and should therefore be valued similarly. **The HCPAC recommends a work RVU of 0.54 for CPT code 97551.**

97552 ***Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers***

The HCPAC reviewed the survey results from 50 occupational therapists, physical therapists, and speech language pathologists for CPT code 97552 and recommends a work RVU of 0.23, which appropriately accounts for the work required to provide the caregiver(s) representing each individual patient with skilled intervention tools (without the patient present). To determine the appropriate work RVU for this service, a custom survey question was added to assess the total time and work RVU for the group as a whole. Additionally, the survey asked respondents to indicate the average number of patients that are typically represented by caregiver(s) in a group caregiver training session. The question yielded a median response of five patients. The survey median work RVU of 1.15 and service period times were divided by the typical number of patients represented by their caregiver(s) per session (i.e., five patients) which reflects the per patient work RVU and service period times expressed in whole numbers. The HCPAC recommends 3 minutes of pre-evaluation time, 9 minutes intra-service time and 2 minutes immediate post-service time.

For this service, the qualified health care professional (QHP) provides group-based skilled intervention as part of a therapy plan of care to introduce strategies and techniques to a group of caregivers to assist the given patient living with functional deficits to competently guide completion of daily life activities. The typical caregiver(s) receiving these skilled interventions are for patients with functional limitations resulting from conditions including, but not limited to, stroke, traumatic brain injury (TBI), various forms of dementia, or autism spectrum disorders. The number of skilled interventions that could be provided is expansive and depends on the needs of each patient to enable completion of daily life activities and/or training for the use of equipment or assistive devices for self-care/home management.

To support the recommended work RVU, the HCPAC compared the surveyed code to key reference service MPC codes 97535 *Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes* (work RVU = 0.45, 15 minutes intra-service time, 21.5 minutes total time) and 97150 *Therapeutic procedure(s), group (2 or more individuals)* (work RVU = 0.29, 10 minutes intra-service and total time). The surveyed code is valued slightly below the key reference services which is appropriate given the total time and lower intensity when compared to the key reference services. The surveyed code is appropriately valued at the recommended work RVU of 0.23 which reflects the training work provided to the caregiver(s) of each patient represented. The typical number of patients represented by caregiver(s) in group-based training is five. The work RVU maintains relativity within the code family and other similar therapeutic group codes. **The HCPAC recommends a work RVU of 0.23 for CPT code 97552.**

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Practice Expense
The Practice Expense (PE) Subcommittee had a robust discussion on the direct practice expense inputs and made no modifications. The PE Subcommittee and specialty societies agreed that expanded detail was needed on the clinical staff and equipment times. This expanded detail is available in the attached PE SOR. **The HCPAC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT codes 97550, 97551, and 97552 will be placed on the New Technology list and be re-reviewed by the HCPAC in three years to ensure correct valuation, patient population, and utilization assumptions.

The RUC filed the HCPAC report as presented.

XVI. New/Other Business (Tab 15)

- A RUC member inquired about formal CPT training for RUC members to further inform members about the CPT process. This was supported by several RUC members and further points were suggested about developing a primer on the CPT process and how the RUC can increase bidirectional communication and increase collaboration. Clarification is recommended on the differences between recommendations to the CPT Editorial Panel, CPT Executive Committee, and CPT Assistant Editorial Board. Moreover, clarification is needed on the timeline of referrals to CPT as it is not always conducive to the joint CPT and RUC cycle timeline. The CPT Editorial Panel Liaison suggested that specialty societies should also work to internally identify ways in which they can integrate the CPT and RUC communication between respective representatives and internal expert panels to benefit the joint processes.

- A RUC member requested that the AMA work with CMS to obtain utilization data related to Medicare Advantage as the program is approaching 50% of the beneficiary population. The member further stated that obtaining this utilization data would help inform the RUC decision-making process with a more comprehensive view of the entire beneficiary population.

- A RUC member sought clarification on the frequency estimates in the SORs and suggested that this be reviewed further by a RUC subcommittee to determine how this question relates to the subsequent recommendation. AMA staff stated that there are two questions on the SOR related to utilization: national expected utilization and Medicare expected utilization. AMA staff further clarified that the RUC uses the information to understand the service and how frequently it is going to be performed and RUC staff cross-checks this information with the CPT CCA for new codes and compares against Medicare data for existing codes. Additionally, this information is also used to compute budget neutrality estimates. The member further questioned the validity of the SOR frequency question. Another RUC member provided clarification that if the frequency estimate is inconsistent with the reporting data, this would trigger a RUC Relativity Assessment Workgroup (RAW) Screen and would be subject to re-review. AMA staff confirmed that after one year of utilization data is available for new codes the data is reviewed and if it is 10% outside of the projected utilization then it is reviewed by the RAW.

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- A RUC member requested a resource that reviews the RAW screens and other Administrative Subcommittee policies. AMA staff directed the member to the Structure and Functions on the RUC Collaboration and offered that the website location could be sent to all RUC participants which would also include the link to the Annotated List of RUC Actions which details all RUC actions.

The RUC adjourned at 11:15 a.m. CT on Saturday, September 24, 2022.

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