AMA/Specialty Society RVS Update Committee
Westin River North, Chicago, IL
September 28-30, 2023

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in September 2023. Doctor Ezequiel Silva, III, called the meeting to order on Thursday, September 28, 2023, at 4:10 p.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
James Blankenship, MD, MHCM
Robert Dale Blasier, MD
Audrey Chun, MD
Joseph Cleveland, MD
Scott Collins, MD
Gregory DeMeo, DO
William Donovan, MD, MPH
Jeffrey P. Edelstein, MD
Matthew J. Grierson, MD
David Han, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
Omar Hussain, DO
M. Douglas Leahy, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
John Proctor, MD
Marc Raphaelson, MD
Richard Rausch, DPT, MBA
Kyle Richards, MD
Christopher Senkowski, MD
Lawrence Simon, MD
Donna Sweet, MD
G. Edward Vates, MD
James C. Waldorf, MD
Thomas J. Weida, MD
Adam Weinstein, MD
David Wilkinson, MD, PhD

RUC Alternates:
Jennifer Aloff, MD
Chester Amedia, MD
Gregory L. Barkley, MD
Eileen Brewer, MD
Neal Cohen, MD
Neeraj Desai, MD
Leisha Eiten, AuD
William Gee, MD
Martha Gray, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kris Kimmell, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Swati Mehrotra, MD
Michael Perskin, MD
Matthew Press, MD
Sanjay Samy, MD
Kurt Schoppe, MD
Eugene Sherman, MD
James L. Shoemaker, MD
Matthew Sideman, MD
Clarice Sinn, DO
Michael J. Sutherland, MD

Mark Villa, MD
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

Ezequiel Silva, III, MD, Chair of the AMA/Specialty Society RVS Update Committee (RUC), introduced himself and welcomed everyone to the in-person RUC meeting.

- Doctor Silva communicated the following guidelines related to confidentiality:
  - All 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.
  - The full lobbying policy can be found on the Collaboration site (Structure and Functions).

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

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) virtual attendees:
  - Perry Alexion, MD
  - Edith Hambrick, MD
  - Gift Tee

- Doctor Silva welcomed the following Contractor Medical Directors:
  - Richard Whitten, MD
  - Barry Whites, MD

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

- Doctor Silva held a moment of silence for two members who passed away this year. Both were dedicated to the RUC and HCPAC processes for 23 years:
  - Mary Foto, OTR
    - AOTA HCPAC Member (1993-2016) also serving as HCPAC Alternate Co-Chair and Co-Chair during her tenure
    - RUC HCPAC Member (2003-2007)

  - John O. Gage, MD
    - ACS RUC Member (1991-2014)

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

- Doctor Silva shared the following procedural issues for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue, and it will be reflected in the minutes.
  - RUC members or alternates sitting at the table may not present or debate for their society.
  - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
  - Tab 11 Telemedicine E/M Services –All RUC members and alternates may participate in the discussion.

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

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

- Doctor Silva shared the process for reviewing Research Subcommittee recommendations:
  - The Research Subcommittee meeting reports are always included in the Research Subcommittee folder.

- For ease, now you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.

III. Director's Report

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

- Ms. Smith welcomed a new AMA RUC staff member:
  - Eileen Donohue, BS – Programming and Events Administrator

- Ms. Smith conveyed the following information regarding the Physician Practice Information (PPI) Survey Update:
  - Mathematica and the AMA completed the internal pre-testing of the online PPI Survey in Summer 2023.
  - The pilot survey was launched in late July – September 2023. To date, 2,600 practices, representing more than 70,000 physicians, have received an email and mailed invitation from Mathematica.
  - An introductory packet of information to the potential survey respondents included a letter showing the support of 173 organizations. We are hopeful that this letter provides an incentive to the practices and health systems to complete the survey.
  - More than half of specialty societies have assisted in communicating the importance of survey participation. We have reached out to the remaining specialty societies to share communications.
  - AMA is enhancing communications and considering other mechanisms to make certain physicians understand that their practice may be invited to participate.
  - The remaining sample is to receive invitations in October. The survey will include more than 10,000 practices in total.
  - Mathematica is also conducting the PPI Survey for non-MD/DO health care professionals and the IDTF community. Those surveys will be initiated in late 2023.

- Ms. Smith reviewed the RUC Database application:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets.
  - Download the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - The database reflects 2021 Medicare claims data.

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

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

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Dec 12, 2023	Jan 17-20, 2024	San Diego, CA	CPT 2025
Apr 2, 2024	Apr 24-27, 2024	Chicago, IL	CPT 2026
Aug 27, 2024	Sept 25-28, 2024	Washington, DC	CPT 2026

- Prepare for 2024 with the authority on the CPT code set. Register here: ama-assn.org/cpt-symposium.

IV. Approval of Minutes from the April 2023 RUC Meeting

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

V. CPT Editorial Panel Update

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

- Update on Panel's Response to SARS-CoV-2 Vaccine
  - Beginning on Aug. 14, 2023, the CPT Editorial Panel approved:
    - Addition of new product codes 91318-91322 (91318, 91319, 91320, 91321, 91322) to identify monovalent vaccine product for immunization against COVID-19 (Pfizer, Moderna);
    - Retained existing Novavax Product Code 91304 for currently authorized vaccine product available for use in the U.S. and the updated (XBB.1.5) vaccine;
    - Deleted and/or revised all other existing COVID codes (product and administration with associated guidelines and parenthetical note deletions/revisions);
    - Added a single administration code (90480) for administration of new (i.e., 91318-91322) and existing (i.e., 91304) COVID-19 vaccine product.
  - All existing CPT codes that describe COVID-19 vaccine products and associated administration codes that end in "A" for products that are no longer covered under an existing Emergency Use Authorization (EUA) or Biologics License Application (BLA) from the US Food and Drug Administration (FDA) will be deleted effective Nov. 1, 2023.

- September 2023 CPT Editorial Panel Meeting
  - 75 items of business
    - Notable agenda items:
      - 5 Digital medicine related Coding Change Applications (CCAs)
      - 27 Category III code applications
      - 2 RUC referrals to CPT
    - The Panel considered and discussed the following notable items:
      - In person-Face to Face Definitions
      - Endovascular Therapy Bundling (Referred by the RUC to CPT)

- Laser Hair Removal for Gender Affirmation Surgery
- Passive Immunization Administration

- CPT Ad Hoc Workgroups
  - Tumor Genomics Neoplastic Targeted GSP Workgroup
    - Co-Chairs: Lawrence Simon, MD and Aaron Bossler, MD
    - Workgroup Charge: To create CPT coding solution(s) for extended / comprehensive genomic testing in tumor/neoplastic conditions, including whole genome sequencing. In the deliberation process, the workgroup will utilize information gained in the AMA's July 2021 Diagnostic Precision Medicine Coding and Payment meeting to determine the feasibility of more granular coding solutions within this space. If deemed appropriate the workgroup may additionally suggest a more granular coding solution for non-neoplastic genomics testing.
    - The GSP Workgroup began its work shortly after the May 2023 meeting.
    - The work has been divided into two subgroups as follows:
      - Subgroup A – Co-Chairs: Aaron Bossler, MD, Madhuri Hegde, MD
      - Subgroup A Areas of Focus: (1) Modification of code 81443 (Genetic testing for severe inherited conditions) and/or development of new code(s) to address current practice for Expanded Genetic Disease Carrier or Diagnostic Panel Testing; and (2) Development of a code(s) for a Basic Genetic Disease panel (CFTR, FMR1, SMN1/2, HBB) Panel Testing.
      - Subgroup B – Co-Chairs: Lawrence Simon, MD, Lawrence Jennings, MD
      - Subgroup B Areas of Focus: (1) Development of a code(s) for Pan-Cancer Hereditary Cancer Panel Testing; and (2) Modification of code 81435 (Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome) or development of new code(s) to better address current practice for Lynch Syndrome/Hereditary Nonpolyposis Colorectal Cancer (HNPCC) Panel Testing
    - Each of the Subgroups have had several calls and continue to have calls to develop the CPT coding structures for their respective areas of focus.
    - The Workgroup's overall goal is to tentatively submit CCAs for consideration by the Panel at its February 2024 or May 2024 meeting.

- Upcoming CPT Editorial Panel Meetings
  - The next Panel meeting is February 1-3, 2024 (Thursday-Saturday) – San Diego, CA
  - The next application submission deadline is November 1, 2023 (for February 1-3, 2024, meeting in San Diego)

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 2024 Medicare Physician Payment Schedule (MFS) Proposed Rule.

- CMS 2024 Proposed Rule
    - On July 13, 2023, 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, 2024. The calendar year (CY) 2024 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 11, 2023, and CMS is actively working on reviewing the comments received. CMS thanks the AMA and other interested parties for their comments.

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

VII. Contractor Medical Director Update

Richard Whitten, MD, FACP, Medicare Contractor Medical Director (CMD), Noridian Healthcare Solutions, LLC, provided the CMD update.

- Misvalued Codes and CPT Parentheticals
    - Two potentially misvalued codes were identified by the Contractor Medical Directors (CMDs)
        - 21210 - Graft bone nasal/Maxillary/Malar areas (includes obtaining graft)
        - 21215 - Graft, bone; mandible (includes obtaining graft)
    - When codes were established, "Graft" referred to an autograft obtained at the time of the procedure, and valuation was on this basis.
    - Now, when these codes are billed, commonly the "graft" is merely a liquid or powder bone matrix poured around a socket area or other dental site.
    - CPT & CPT Assistant Editorial Panels working to clarify parentheticals.

- Misvalued Codes or Utilization
    - Example from Supplemental Medical Review Contractor (SMRC) reviews:
        - 55873 *Cryosurgical ablation of the prostate (includes ultrasound guidance and monitoring)*
        - CPT 2008, RUC valued in 2009 for full assessment and ablation, and made part of CPT 2010 / MPFS 2010
        - Valued as a single ablative procedure.
        - Now being used with increasing frequency as a serial procedure, repeated over and over on the same patient (without reduced service modifier), generally after repeated pre-op full workup.
    - What else may this apply to? Please watch as come through CPT & RUC.

- Dental – Expansion of Exceptions to the Dental Exclusion
    - 2023 MPFS Final Rule: "Specifically, we are amending § 411.15(i)(3)(i), to allow for payment under Medicare Part A and Part B for dental services, furnished in an inpatient or outpatient setting, that are inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services.
    - 2024 MPFS Proposed Rule: Will make amendments to specify that payment under Medicare Parts A and B can be made for an oral or dental examination, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection, prior to, or contemporaneously with:
        - Treatment for head and neck cancers
        - Proposed:
            - Chemotherapy when used in the treatment of cancer;
            - CAR-T Cell therapy, when used in the treatment of cancer; and
            - Administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer.

- Dental – CMD Multi-Medicare Administrative Contractor (MAC) Workgroup Assessment
    - Payment may be made in Parts A and/or B.
    - MAC discretion as to how to operationalize final rule:
        - i.e., Coverage and Payment of dental services are up to MAC discretion-including pricing.
    - Current Dental Terminology (CDT) and/or CPT/HCPCs codes can be billed at this time.
    - "Inextricable link" must be demonstrated in the medical records between oral surgeons and another medical professional.
    - All other clinical scenarios not mentioned in Final Rule are up to MAC discretion for payment.

- Dental – CMD Multi-MAC Workgroup Actions
    - Multi-MAC Dental workgroup formed
    - Multi-MAC Billing and Coding article developed
    - Periodic meetings with CMS
    - Collaboration with ADA and AAOMS
    - Collaboration with AMA/CPT

- CMD Workgroup: Biosimilars and Administration Codes
    - Agreement that payment / reimbursement should be independent of specialty.
    - Agreement that coding and payment should directly correlate with side effects (and therefore work, practice expense, and practice liability) for the administration.

- CMD Workgroup: Pain Rx
    - Multi-MAC Subject Matter Expert Advisory Committee ("CAC") was held October 19, 2023.
    - Individual MACs hold individual, open Public Meetings.
    - Expect Further Release late this fall.
    - Cervical Fusion Workgroup SME Meeting was 8/16/2023.
    - Trigger Point Workgroup SME Meeting was 4/27/2023.

- CMD Workgroup – Botulinum Toxin
    - Multi-MAC Subject Matter Expert Advisory Committee ("CAC") was held on October 19, 2023.

- Draft Workgroup Local Coverage Determination (LCD) DL39116
  - Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound.
  - Non-coverage LCD FINAL to be published in the Database next couple weeks.
  - Effective mid-November 2023.

- CMD Workgroup: Superficial Radiation Therapy for non-Melanoma Skin Cancers
  - Rapidly increasing utilization
  - Long-term outcome concerns vs. Mohs surgery (and other options)
  - Possible draft LCD

VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, provided the Washington report focusing on AMA Advocacy and the AMA response to the Medicare Physician Payment System Proposed Rule, Telehealth policy, and the Merit-based Incentive Payment System (MIPS).

- **AMA Recovery Plan for America's Physicians: Reforming Medicare Payment**

- Medicare Physician Payment Reform
  - Medicare reform principles supported by more than 120 other medical societies to guide advocacy efforts on Medicare physician payment reform.
  - Multi-pronged approach:
    - Congress needs to establish a permanent, annual inflationary Medicare physician payment update that keeps up with the cost of practicing medicine and encourages practice innovation.
    - Budget neutrality requirements need to be revised to:
      - Prevent erroneous utilization estimates from causing inappropriate cuts.
      - Clarify the types of services that should and should not be subject to budget neutrality adjustments.
      - Raise the projected expenditure threshold that triggers the budget neutrality adjustment, which has been in place since 1992.
    - Congress should reduce the burden of MIPS and prevent unfair penalties.
    - Incentives for participating in alternative payment models (APMs) need to be extended.

- The Value in Health Care Act
  - Bipartisan legislation, H.R. 5013, the Value in Health Care Act, which would:
    - Extend 5% APM incentive payments for two years.
    - Freeze the 50% revenue threshold that physicians in value-based care models must meet to qualify for the incentive payments.
    - Give HHS Secretary authority to establish lower thresholds for physicians in episode-based payment models that, by definition, involve a smaller percentage of the patient population.
  - AMA joined 16 other organizations, including ACP, AAFP, and AAOS, in a letter of support.
  - AMA participates in a broad coalition to advocate for passage of this bill.

- Merit-Based Incentive Payment System (MIPS) Legislative Asks
    - AMA-led workgroups consisting of national specialty and state medical societies identified and prioritized a small number of high-impact changes to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) statute to address problems in MIPS.
    - No price tag.
    - Recommendations to fix steep and unfair penalties:
        - Freeze the performance threshold at 60 points for three years.
        - Eliminate MIPS win-lose style payment adjustments and put a portion of physicians' annual payment update (i.e., Medicare Economic Index [MEI]) at risk.
        - Reinvest penalties in bonuses and to aid under-resourced practices in value-based care.
    - Recommendation to ensure physicians receive timely and actionable MIPS and claims data:
        - Exempt from penalties for any physician who does not receive at least three quarterly MIPS data reports during the performance period.
    - Recommendations to make MIPS more clinically relevant and less burdensome:
        - Award cross-category credit.
        - Allow physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means.
        - Improve cost category by developing measures that target variability within the physician's ability to influence.
        - Align cost and quality goals.
        - Incentivize physicians to test new or significant revised measures, including qualified clinical data registry (QCDR) measures, by awarding credit for reporting for three years.

- Budget Neutrality
    - The AMA and our Medicare Payment Reform Workgroup have developed a proposal to improve the current statutory provision on budget neutrality in the physician payment schedule.
    - The proposal has 4 elements:
        - For future budget neutrality adjustments that involve an estimate of utilization for a new service, CMS would be required to review the actual claims data for the first year that the code is implemented and then, if it turns out that their estimate was too high or too low, they will revise the budget neutrality adjustment in the subsequent year to reflect the actual utilization.
        - The current budget neutrality limit of $20 million, which represented 0.06% of Medicare allowed charges in 1992, would be increased to a number that represents that same percentage of total allowed charges for 2024. (Estimated to be $53 million.)
        - CMS would be required to update prices for the key components of direct practice expenses, which are clinical labor and supplies and equipment, at the same time and no less often than every 5 years.
        - Certain types of services would be exempt from budget neutrality adjustments, including new technology that has never been paid for before, new Medicare preventive services, new health professionals that are added, and services that are developed specifically for use in alternative payment models.

  - We have had discussions with key Hill staff about these ideas and also shared with them a cost analysis indicating that the Congressional Budget Office (CBO) would be likely to give these proposals only a minimal score, if any.

- H.R. 2474, The Strengthening Medicare for Patients and Providers Act
  - Bipartisan legislation to replace current law updates (e.g., -1.25% in 2024) with updates based on the increase in the MEI.
    - May 3, 2023, letter from organized medicine to Congress in support.
  - We have been working very hard to increase the number of cosponsors from both parties. As of this month, there are 39 cosponsors.
  - There is growing recognition in Congress of the need for physician payment rates to reflect inflation in their costs, but it's critically important for physicians to keep pressing their Members of Congress on this issue.
  - Let them know the financial pressures you face, how important this is, and how the lack of an update affects your patients' care.
  - The 2024 MEI is 4.5%, and although it is not estimated to stay that high in the future, as you can imagine this bill would likely have a very high score.
  - CBO scores cover a 10-year period, so if the bill was passed this year, it would involve paying for a 4.5% increase for 10 years, a more than 3% increase for 9 years, and 2-3% increases each year thereafter.
    - This could total more than $100 billion CBO score over 10 years.
  - In addition, there are other factors that can further increase the score.
    - For example, some previous CBO scores have almost doubled what would be spent for physician services because Medicare Advantage increases are tied to growth in regular Medicare.
  - But there is also a cost to not fixing this problem. As more Medicare physician services shift to hospital outpatient clinics, for example, both the Medicare program and beneficiaries will actually spend more.

- Medicare Physician Payment Reform
  - The AMA has released several articles and comments related to Medicare physician payment reform:
    - Dallas Morning News: Medicare bill can help physicians and patients (July 2023)
    - The Hill: Inaction on Medicare payment reform jeopardized quality care (July 2023)
    - Fox News: AMA Calls for Reimbursement Reform (August 2023)
    - AMA: House member to leadership: Fix Medicare now (August 2023)
    - Fierce Healthcare: Provider groups warn proposed Medicare payment cuts will pinch docs, hamper access to care (September 2023)
    - The Washington Times: Doctors need a fair payment system to care for older adults (September 2023)
    - AMA Gap Chart

- Keep Up the Pressure on Congress
  - The threat of a government shutdown is looming.
  - Important issues like fixing the broken Medicare physician payment system are in danger of getting lost in the shuffle.
  - Go to FixMedicareNow.org and tell your legislators to cosponsor H.R. 2474 to provide annual MEI updates to physician payment.

- **AMA Comments: 2024 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Proposed Rule**

- Reduction to Medicare Conversion Factor (CF)
    - The proposed rule predicts a 3.36 percent reduction in the 2024 Medicare conversion factor, lowering it from $33.8872 to $32.7476. The anesthesia conversion factor is proposed to be reduced from $21.1249 to $20.4370.
    - The AMA continues to underscore our concerns that these proposed cuts will have far-reaching implications for both physicians and the patients they serve.
    - While we appreciate that Congress partially mitigated the 4.5 percent cut to the MFS rates, the forthcoming -1.25 percent reduction in 2024 compounded by a two percent reduction that took effect for 2023, amplifies the financial stress on physician practices.
    - We urged both Congress and CMS to collaborate urgently to address this pressing issue and ensure that physician practices can continue to provide exceptional care without the strain of financial adversity.

- Mitigation of Budget Neutrality Cuts from the Evaluation and Management (E/M) Add-on Code
    - The AMA greatly appreciates the reduction in the utilization assumption for the G2211 E/M add-on code from 90 percent under the previous administration to 38 percent in the current Proposed Rule.
    - Nonetheless, we continued to raise concerns that this estimate is too high based on outstanding questions about when to bill this code and patient cost-sharing.
    - We urge the agency to further refine these assumptions to prevent unwarranted reductions in the Medicare conversion factor.

- Key Proposals in Comments
    - AMA appreciated that CMS adopted 91 percent of the RUC recommendations, including a new code to capture the costs of providing a female pelvic exam.
    - We thanked CMS for postponing the implementation of updated MEI weights and for acknowledging the AMA's current survey to collect practice cost data from physician practices.
    - AMA supported the proposed one-year delay of the requirement to bill split or shared visits based on which practitioner spends more than half of the total time with the patient. We strongly urged CMS to adopt the CPT guidelines for determining when a physician may report a split or shared E/M visit based on medical decision making (MDM).
    - We supported CMS's proposal to pause the implementation of the appropriate use criteria (AUC) Program and to rescind current program regulations until the necessary modifications can be made.

- Telehealth
    - Strong support for CMS proposals implementing Consolidated Appropriations Act (CAA) 2023.
    - Strongly urge Biden Administration to support legislation to permanently extend these Medicare telehealth policies.
    - Recommend permanently lifting the frequency limit on SNF telehealth visits.
    - Direct Supervision: recommend permanently allowing supervising physician to be present and immediately available through real-time audio-visual interactive communications.
    - Teaching Physicians: urge CMS to maintain virtual supervision of residents in all settings permanently.

  - Home Address: urges CMS to allow physicians to continue to render telehealth visits from locations other than their primary practice setting without having to add their home address to their Medicare enrollment.

- Merit-based Incentive Payment System (MIPS)
  - The AMA strongly recommended that CMS take steps to alleviate the burden on MIPS eligible physicians during the 2024 performance period and at a minimum, CMS should maintain the current performance threshold at 75 points to prevent undue penalties.
  - We reiterated our disappointment that MIPS Value Pathways (MVPs) do not address any of the well-documented problems with MIPS. "By carrying the flawed MIPS policies over into MVPs, CMS is doing the same thing and expecting a different result."
  - We strongly recommended removing the Total Per Capita Cost measure from MIPS and opposed CMS' proposed increase to the data completeness requirements.

- **Emerging MIPS Situation**

- 2022 MIPS Scores / 2024 Payment Adjustments
  - On August 10, CMS made available 2022 MIPS performance feedback, which determines whether physicians and eligible clinicians will receive a positive, neutral, or negative payment adjustment on Medicare services furnished in 2024.
  - The AMA is hearing alarming reports of physicians facing MIPS penalties in 2024 on top of the 3.36% reduction to the Medicare conversion factor.
  - If there are any errors, you should consider submitting an appeal, also called a targeted review. The deadline to submit a targeted review is Oct. 9, 2023. Find out more information at qpp.cms.gov.

- Your Help is Needed
  - AMA is pushing CMS to release data on the 2022 MIPS scores but in the past, they have not released this information until the following year (e.g., mid-2024 for 2022 performance data).
  - You can help the AMA advocate against Medicare physician payment cuts in 2024 by sharing your 2022 MIPS feedback and any discrepancies or changes from prior years.

- Ms. Hananoki addressed questions from the attendees:
  - A RUC member inquired about the MIPS data and related high performers and low performers. Ms. Hananoki responded that for 2023, 100 points received a 2.34% update and over the years, it has ranged from 1.68 to 2.34 which is a significant leap. The AMA hypothesizes that in 2022 when CMS moved away from the automatic hardship exemption and instead required an application, there may have been a number of small rural safety nets or under resourced practices that did not pivot and submit an application. Further, CMS increased the weight of the cost category during 2020 and 2021 due to COVID and increased the performance threshold. Therefore, the AMA does not know the higher performers or the lower end performers and we won't know until CMS releases the experience report mid-year 2024. The AMA is actively working with CMS improve their data files so that we are able to more easily identify what is driving performance.
  - The RUC member further stated that a recent MedPAC report demonstrated that Medicare Advantage did not realize the savings as anticipated but actually overspent and inquired about the impact of that on Medicare programs overall. The member also inquired about how this information is being disseminated to the public. Ms. Hananoki responded that AMA staff will keep a close eye on this and will continue to publicly

comment on these types of issues and continue to advocate for the AMA Recovery Plan for America's Physicians.
- Further, to help the public better understand the issues at hand, the AMA is placing op-eds in local newspapers to target specific congressional members and their constituents to drive the issue to the Hill. Ms. Hananoki also encouraged RUC participants to visit the FixMedicareNow.org website and refer patients to the Get Involved page, and further, the share your story option, so that the AMA can build that into the broader messaging.
- A member inquired about the need for Medicare Advantage data for the RUC database. The member emphasized that this would help determine accurate utilization assumptions and better reflect the Medicare population.

IX. Relative Value Recommendations for CPT 2025

Hand, Wrist, & Forearm Repair and Reconstruction (Tab 4)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Jeffrey Kozlow, MD (ASPS), Anne Miller, MD (ASSH), Noah Raizman, MD (ASSH), Christopher Shale, MD (ASPS)

In April 2022, the Relativity Assessment Workgroup (RAW) identified services performed by the same physician, on the same date of service, 75% of the time or more. Families of codes 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 RAW requested action plans for September 2022 to determine if specific code bundling solutions should occur for the following 26480 and 25447. In September 2022, the RUC referred codes 26480 and 25447 to the CPT Editorial Panel for a code bundling solution in CPT 2025.

In April 2023, when AMA staff re-ran the reported together screen, CPT codes 25310 and 25447 appeared as typically reported together. Since a CCA for a bundling solution for 26480 and 25447 was at the CPT Editorial Panel, the specialty societies were notified and agreed to also create a code bundling solution for 25310 and 25447. In May 2023, the CPT Editorial Panel approved a new bundled code (25448) to report intercarpal or carpometacarpal joint suspension arthroplasty, including transfer or transplant of tendon, with interposition when performed. In addition, current code 25447 was revised to clarify that the code only included interposition of a tendon and not suspension. The Panel approved the new code and revisions to existing codes for CPT 2025 to accomplish the bundling request and reinforce correct coding for these services.

CPT codes 25310, 25447, 26480, and new code 25448 were surveyed for the September 2023 RUC meeting. The specialties elected not to survey related codes 25312 and 26483 because they are low volume codes, and the typical patient is different. For these two codes, the typical patient is a trauma patient not related to carpometacarpal (CMC) arthroplasty and the bundling solution approved by the CPT Editorial Panel. The surveyed codes involve both the treatment of trauma and chronic conditions. The RUC agreed that, although the utilization for codes 25312 and 26483 are both low, after implementation of new code 25448 and revised code 25447, along with education about these coding changes through CPT Assistant, the utilization will decrease even more dramatically for both codes.

25310 ***Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon***
The RUC reviewed the survey results from 100 surgeons and determined that the survey median work RVU of 9.50 appropriately accounts for the physician work involved in this service. The RUC recommends 30 minutes pre-service evaluation time, 10 minutes positioning time, 10 minutes

scrub/dress/wait time, 60 minutes intra-service time, and 25 minutes immediate post-service time, 0.5-99238 discharge day management visit, 1-99214 and 3-99213 office visits, for 263 minutes total time as supported by the survey. The RUC acknowledged an increase in post-service work and believes there is evidence that the current work RVU for 25310 is potentially misvalued due to the changes in post-operative office work that is reflective of recent changes in the value and reporting guidelines for office visit E/M codes. Although the number of postop visits has not changed, the level of visits has changed as supported by both medical decision-making (MDM) and total time on the day of the encounter.

To justify a work RVU of 9.50, the RUC compared CPT code 25310 to the top key reference service code 26356 *Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon* (work RVU = 9.56, 60 minutes intra-service time and 277 minutes total time) and the second key reference service code 23430 *Tenodesis of long tendon of biceps* (work RVU = 10.17, 60 minutes intra-service time and 237 minutes total time) noting that both key reference services represent similar tendon repair work. The identical intraoperative time and similar total time when compared with the surveyed code is supportive of the recommended work RVU. Further, the intensity and complexity measures confirm that the surveyed code involves a similar intensity of physician work relative to the key reference service codes. Of those survey respondents who selected the key reference services 26356 and 23430, 71% and 69% deemed them identical to 25310 in overall intensity/complexity, respectively.

For additional support, the RUC compared CPT code 25310 to MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, 60 minutes intra-service time and 183 minutes total time) and 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time) and noted that the comparison codes have identical intra-service time and appropriately bracket the surveyed code. The RUC also reviewed a table of all 90-day global codes reviewed by the RUC in the past 10 years with an intra-time of 60 minutes and total time between 225-325 minutes and agreed that the median work RVU of 9.50 appropriately ranked code 25310 within this set of codes. The RUC concluded that CPT code 25310 should be valued at the median work RVU as supported by the survey, MPC codes, and recently reviewed codes with similar time. **The RUC recommends a work RVU of 9.50 for CPT code 25310.**

25447 ***Arthroplasty, intercarpal or carpometacarpal joints; interposition (eg, tendon)***
The RUC reviewed the survey results from 109 surgeons and determined that maintaining the current work RVU of 11.14 appropriately accounts for the physician work involved in this service. The RUC recommends 33 minutes pre-service evaluation time, 10 minutes positioning time, 10 minutes scrub/dress/wait time, 75 minutes intra-service time, and 25 minutes immediate post-service time, 0.5-99238 discharge day management visit, 1-99214 and 3-99213 office visits, for 281 minutes total time as supported by the survey. The SOR provides a detailed description and supporting information for the increases in work and time associated with the post-operative patient care for code 25447:

Discussion of Postoperative Office Visits

POV1 (24-48 hours after surgery). For this visit, MDM is moderate: (1) The patient has a chronic condition with side effects of surgery (pain, loss of hand/digit function), where the patient is not at the treatment goal of complete pain relief and restoration of grip and pinch strength. (moderate). (2) Discussion of patient management including fabrication of a patient-specific splint with the OT will occur (moderate). (3) Prescription drug management, both narcotic and nonnarcotic pain medication (moderate). With respect to time, the patient will arrive with a splint and large bulky dressing that will

take time to take down; assess and document wound status; check for drainage, hematoma, signs of infection; assess and document circulation, sensation, and motor function status; assess and document alignment of thumb and fingers; and assess and document pain and then redress the wound. Time is needed for counseling about pain and swelling mitigation techniques, appropriate use of multimodal pain management, and activity restrictions. Time is needed to contact OT to discuss fabrication of a patient-specific splint. Time is needed to review the findings at surgery and postoperative imaging with the patient, review the care plan, and answer patient/family questions. Time is also needed to complete medical records, file insurance forms, and update other providers. Time is needed to provide a note for work status. The total physician/QHP time for these activities is estimated to be approximately 37 minutes which, in addition to MDM, supports 99214.

POV2 (10-14 days postop): For this visit, MDM is still moderate based on the patient still having a chronic condition from surgery and not at treatment goal; continued discussion with external OT regarding patient management and the care plan which is reviewed and revised as appropriate based on patient progress; and narcotic/nonnarcotic medication for pain will be considered and ordered as required. Total time is estimated at 33 minutes. However, the survey median selected level for this visit was 99213, therefore we recommend 99213 for the second visit.

POV3: (~5-6 weeks postop): For this visit, MDM is still moderate based on the patient still having a chronic condition from surgery and not at treatment goal; continued discussion with external OT regarding patient management and the care plan which is reviewed and revised as appropriate based on patient progress; and medication for pain will be considered and adjusted as required. Total time is estimated at 26 minutes. However, the survey median selected level for this visit was 99213, therefore we recommend 99213 for the third visit.

POV4: (~9-10 weeks postop): For this visit, MDM is still moderate based on the patient still having a chronic condition from surgery and not at treatment goal and continued discussion with external OT regarding patient management and the care plan which is reviewed and revised as appropriate based on patient progress. Drug management will likely be low MDM. Total time is estimated at 24 minutes. Although 99214 may be supported, the survey median selected level for this visit was 99213, therefore we recommend 99213 for the fourth visit.

In addition, the specialties noted that patient care will continue for a minimum of 6 months postoperatively and up to a year after surgery, by which time it is expected that the treatment goal for the typical patient will be achieved.

The RUC discussed the decrease in intra-service time for the surveyed code. This code was last surveyed in 2005 and the specialties attested that the technique is the same, but physicians are now more familiar with the procedure and thus it may be performed with less time. The RUC agreed that the changes to the work and time of post-operative care, along with higher surveyed pre and immediate post-service time not recognized in 2005, will offset the decrease in survey intra-service time.

By maintaining the current value, the total global work and intra-operative intensity for 25447 does not change. More specifically, the specialties provided an intra-service work per unit time (IWPUT) analysis that supports maintaining the current RVW for 25447. The analysis shows that although the intra-service time decreased, the post-operative work increased, such that the resulting intra-service work per unit of time is essentially identical. This supports the belief that the procedure and the intra-operative intensity has not changed. A decrease in work attributed to a decrease in intra-service time and an increase in work attributed to an increase in post-operative work result in no change in the intensity of the procedure and total work.

To justify a work RVU of 11.14, the RUC compared CPT code 25447 to the top key reference service code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU = 13.16, 75 minutes intra-service time and 252 minutes total time) and noted that the intra-service time is identical and total time is similar to the surveyed code, but the reference code is much more intense, justifying the higher work value. The RUC also compared CPT code 25447 to the second key reference service code 29888 *Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction* (work RVU = 14.30, 98 minutes intra-service time and 295 minutes total time) and noted that the reference service has more intra-service and total time and is appropriately valued higher than 25447. The procedures are similar in that they incise a joint capsule, excise bone, and transpose local tissue as part of the repair.

For additional support, the RUC compared CPT code 25447 to MPC code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU = 11.90, 75 minutes intra-service time and 233 minutes total time) and noted that the surveyed code has identical intra-service time yet more total time and is therefore valued slightly higher than the comparator code. The RUC concluded that the value of CPT code 25447 should be maintained at 11.14 work RVUs with time components supported by the survey. **The RUC recommends a work RVU of 11.14 for CPT code 25447.**

25448 ***Arthroplasty, intercarpal or carpometacarpal joints; suspension, including transfer or transplant of tendon, with interposition, when performed***

The RUC reviewed the survey results from 95 surgeons and determined that the survey median work RVU of 13.90 appropriately accounts for the physician work involved in this service. The RUC recommends 33 minutes pre-service evaluation time, 10 minutes positioning time, 10 minutes scrub/dress/wait time, 90 minutes intra-service time, and 25 minutes immediate post-service time, 0.5-99238 discharge day management visit, 1-99214 and 3-99213 office visits, for 296 minutes total time as supported by the survey. The SOR provides a detailed description of the post-operative office visits associated with code 25448:

Discussion of Postoperative Office Visits

POV1 (24-48 hours after surgery). For this visit, MDM is moderate: (1) The patient has a chronic condition with side effects of surgery (pain, loss of hand/digit function), where the patient is not at the treatment goal of complete pain relief and restoration of grip and pinch strength. (moderate). (2) Discussion of patient management including fabrication of a patient-specific splint with the OT will occur (moderate). (3) Prescription drug management, both narcotic and nonnarcotic pain medication (moderate). With respect to time, the patient will arrive with a splint and large bulky dressing that will take time to take down; assess and document wound status; check for drainage, hematoma, signs of infection; assess and document circulation, sensation, and motor function status; assess and document alignment of thumb and fingers; and assess and document pain and then redress the wound. Time is needed for counseling about pain and swelling mitigation techniques, appropriate use of multimodal pain management, and activity restrictions. Time is needed to contact OT to discuss fabrication of a patient-specific splint. Time is needed to review the findings at surgery and postoperative imaging with the patient, review the care plan, and answer patient/family questions. Time is also needed to complete medical records, file insurance forms, and update other providers. Time is needed to provide a note for work status. The total physician/QHP time for these activities is estimated to be approximately 37 minutes which, in addition to MDM, supports 99214.

POV2 (10-14 days postop): For this visit, MDM is still moderate based on the patient still having a chronic condition from surgery and not at treatment goal; continued discussion with external OT regarding patient management and the care plan which is reviewed and revised as appropriate based on patient progress; and narcotic/nonnarcotic medication for pain will be considered and ordered as

required. Total time is estimated at 33 minutes. However, the survey median selected level for this visit was 99213, therefore we recommend 99213 for the second visit.

POV3: (~5-6 weeks postop): For this visit, MDM is still moderate based on the patient still having a chronic condition from surgery and not at treatment goal; continued discussion with external OT regarding patient management and the care plan which is reviewed and revised as appropriate based on patient progress; and medication for pain will be considered and adjusted as required. Total time is estimated at 26 minutes. However, the survey median selected level for this visit was 99213, therefore we recommend 99213 for the third visit.

POV4: (~9-10 weeks postop): For this visit, MDM is still moderate based on the patient still having a chronic condition from surgery and not at treatment goal and continued discussion with external OT regarding patient management and the care plan which is reviewed and revised as appropriate based on patient progress. Drug management will likely be low MDM. Total time is estimated at 24 minutes. Although 99214 may be supported, the survey median selected level for this visit was 99213, therefore we recommend 99213 for the fourth visit.

In addition, the specialties noted that patient care will continue for a minimum of 6 months postoperatively and up to a year after surgery, by which time it is expected that the treatment goal for the typical patient will be achieved.

The new bundled code encompasses the work of 25447 and the additional complex work of drilling and creating a hole through the base of the first metacarpal for passage of the radial half of the flexor carpi radialis (FCR) from the second metacarpal to the first metacarpal. The position of the thumb and tension on the tendon transfer are carefully assessed prior to suturing the tendon to itself in the arthroplasty space created by the excised trapezium. This additional operative maneuver is technically challenging, especially considering that the patient has arthritis with brittle bones such that the tension needs to be enough for suspension, but not too much to result is bone fracture. This additional work beyond the work 25447 is much more intense, resulting in a higher for 25448 when compared with 25447.

To justify a work RVU of 13.90, the RUC compared CPT code 25448 to the top key reference service code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU = 13.16, 75 minutes intra-service time and 252 minutes total time) and noted that the surveyed code has more intra-service and total time and is appropriately valued higher than the reference service. The RUC also compared CPT code 25448 to the second key reference service code 29888 *Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction* (work RVU = 14.30, 98 minutes intra-service time and 295 minutes total time) and noted that the reference service has more intra-service time and is more intense than the surveyed code, therefore it is appropriately valued higher.

For additional support, the RUC compared CPT code 25448 to MPC codes 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.50, 90 minutes intra-service time and 255.5 minutes total time) and 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time and 283 minutes total time) and noted that the comparison codes have identical intra-service time and appropriately bracket the surveyed code. The RUC concluded that CPT code 25448 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 13.90 for CPT code 25448.**

26480 ***Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon***

The RUC reviewed the survey results from 99 surgeons and determined that the survey median work RVU of 9.50 appropriately accounts for the physician work involved in this service. The RUC recommends 30 minutes pre-service evaluation time, 10 minutes positioning time, 10 minutes

scrub/dress/wait time, 60 minutes intra-service time, and 25 minutes immediate post-service time, 0.5-99238 discharge day management visit, 1-99214 and 3-99213 office visits, for 263 minutes total time as supported by the survey. The RUC concurred that the two surveyed codes 25310 and 26480 have identical physician work and time components. The current survey of the two codes together demonstrates the exact same time and intensity.

As with code 25310, the RUC acknowledged an increase in post-service work and believes there is evidence that the current work RVU for 26480 is potentially misvalued due to of the changes in post-operative office work that is reflective of recent changes in the value and reporting guidelines for office visit E/M codes. Although the number of post-op visits has not changed, the level of visits has changed as supported by both medical decision-making (MDM) and total time on the day of the encounter.

To justify a work RVU of 9.50, the RUC compared CPT code 26480 to the top key reference service code 26356 *Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon* (work RVU = 9.56, 60 minutes intra-service time and 277 minutes total time) and the second key reference service code 23430 *Tenodesis of long tendon of biceps* (work RVU = 10.17, 60 minutes intra-service time and 237 minutes total time) noting that both key reference services represent similar tendon repair work, identical intra-service time, and similar total time as the surveyed code. Further, the intensity and complexity measures confirm that the surveyed code is similar to the key reference service codes.

For additional support, the RUC compared CPT code 26480 to MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, 60 minutes intra-service time and 183 minutes total time) and 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time) and noted that the comparison codes have identical intra-service time and appropriately bracket the surveyed code. The RUC also reviewed a table of all 90-day global codes reviewed by the RUC in the past 10 years with an intra-time of 60 minutes and total time between 225-325 minutes and agreed that the median work RVU of 9.50 appropriately ranked code 25310 within this set of codes. The RUC concluded that CPT code 26480 should be valued at the survey median work RVU as supported by the survey, MPC codes, and recently reviewed codes with similar time, and to restore relativity within the family. **The RUC recommends a work RVU of 9.50 for CPT code 26480.**

Practice Expense
The PE Subcommittee made a single modification to the spreadsheet; EF023 *table, exam* was changed to EF031 *table, power* as the power table is typical in the orthopedic surgeon's office. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

RUC Flag
The RUC recommends that CPT codes 25312 and 26483 be reviewed by the Relativity Assessment Workgroup after three years of data are available to determine whether the utilization of these low-volume codes has further decreased.

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

CAR-T Therapy Services (Tab 5)
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Facilitation Committee #3

In May 2023, the CPT Editorial Panel approved the addition of four codes to report Chimeric Antigen Receptor T-cell (CAR-T) Services, added a new subsection with guidelines, and deleted four Category III codes. Genetic alteration and cell expansion are performed by biotechnology companies operating according to FDA stringent manufacturing processes. Therefore, the new codes describe only those steps of this complex process that are currently performed or supervised by physicians. Moreover, in the U.S., the collection, testing, preparation, storage and transport of blood and blood components must comply with FDA regulations and guidance documents which are accounted for in the recommendations for the code family.

38225 ***Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day***
The RUC reviewed the survey results from 42 pathologists and determined that the survey 25th percentile work RVU of 1.94 appropriately accounts for the physician work involved in this service. New code 38225 describes lymphocyte collection. The RUC recommends 30 minutes pre-service time, 36 minutes intra-service time, 20 minutes post-service time, and 86 minutes total time as supported by the survey. The RUC acknowledged that 38225 is a lengthy, 8-hour procedure and the portion that the physician is face-to-face with the patient is typically 36 minutes, while the physician remains immediately available for the entirety of the procedure. The RUC clarified that two different physicians typically report codes 38225 and 38226, therefore there is no overlap of pre- and post-service work between the two codes.

To justify a work RVU of 1.94, the RUC compared CPT code 38225 to the top key reference service code 38241 *Hematopoietic progenitor cell (HPC); autologous transplantation* (work RVU = 3.00, 60 minutes intra-service time and 108 minutes total time) and noted that the reference code has 24 minutes more intra-service time and is more intense than the surveyed code and is therefore appropriately valued higher. It is also specific to stem cells. The RUC referenced CPT code 36511 *Therapeutic apheresis; for white blood cells* (work RVU = 2.00, 30 minutes intra-service time and 85 minutes total time) for further comparison, noting that both codes are cell collection services. However, 38225 is more complex, is not a therapeutic procedure, and is specific to lymphocytes whereas 36511 is a therapeutic leukocyte procedure.

For additional support, the RUC compared CPT code 38225 to MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time) and noted that the surveyed code requires more time and is therefore valued higher than the comparator code. The RUC concluded that CPT code 38225 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.94 for CPT code 38225.**

38226 ***Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)***
The RUC reviewed the survey results from 32 pathologists and determined that the survey 25th percentile work RVU of 0.79 appropriately accounts for the physician work involved in this service. New code 38226 describes the post-collection handling of the lymphocytes and preparation of the

cells to be shipped to the manufacturer. The RUC recommends 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time as supported by the survey.

To justify a work RVU of 0.79, the RUC compared CPT code 38226 to the top key reference service code 80504 *Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.* (work RVU = 0.91, 30 minutes intra-service time and total time) and noted that the reference code has 12 minutes more intra-service time than the surveyed code and therefore is appropriately valued higher. The RUC advised that the second key reference service code 38210 *Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion* (work RVU = 1.57, 60 minutes intra-service time and 75 minutes total time) should not have been included on the RSL nor used as a key reference service. CPT code 38210 has a Medicare Status of "I" which is not valid for Medicare purposes and has no claims data. The RUC concurred that the recommended value is well supported by the first key reference service. The RUC also referenced CPT codes 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU = 0.94, 40 minutes intra-service time and total time) and 86079 *Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report* (work RVU = 0.94, 30 minutes intra-service time and total time) to support the RUC recommended work RVU.

For additional support, the RUC compared CPT code 38226 to MPC codes 85097 *Bone marrow, smear interpretation* (work RVU = 0.94, 25 minutes intra-service and total time) and 88305 *Level IV - Surgical pathology, gross and microscopic examination…* (work RVU = 0.75, 25 minutes intra-service and total time) and noted that the comparison codes appropriately bracket the surveyed code. In addition, MPC code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time and 26 minutes total time) offers a solid comparison with similar intra-service and total time and a similar amount of physician work as the surveyed code. The RUC concluded that CPT code 38226 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.79 for CPT code 38226.**

38227 ***Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration***

The RUC reviewed the survey results from 32 pathologists and determined that the survey 25th percentile overestimated the physician work typically required to perform this service. New code 38227 describes receipt of and handling and additional preparation of the genetically altered lymphocytes before administration. The RUC recommends a direct work RVU crosswalk to CPT code 92240 *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (work RVU= 0.80, 20 minutes intra-service time and 22 minutes total time), noting that both services involve an identical amount of intra-service time and similar total time. The RUC recommends the following physician time components: 1-minute pre-service time, 20 minutes intra-service time, 3 minutes immediate post-service time. The RUC reduced the pre and post-service times from the survey median of 5 minutes pre-service evaluation time to 1 minute, like the crosswalk code, and 5 minutes immediate post-service time to 3 minutes recognizing that the post-service work involves more than just signing the report but also takes into account the rules and regulations required with this service and paperwork for the manufacturer.

The RUC concurred that applying CPT code 92240 as a direct work RVU crosswalk to CPT code 38227 is supported by several other XXX global codes with similar intra-service time and similar total time, namely, CPT code 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual* (work RVU= 0.85, 23 minutes intra-service and total time) and CPT code 74485 *Dilation of ureter(s) or urethra, radiological supervision and interpretation* (work RVU= 0.83, 20 minutes intra-service time and 28 minutes total time). The RUC concluded that CPT code 38227 should be valued based on a direct work RVU crosswalk to CPT code 92240 and agreed the crosswalk value slightly below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 0.80 for CPT code 38227.**

38228 ***Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous***
The RUC reviewed the survey results from 35 oncologists and hematologists and determined that a work RVU of 3.00, which represents both the survey 25th and median values, appropriately accounts for the physician work involved in this service. New code 38228 describes administration of genetically altered lymphocytes. The RUC recommends 40 minutes pre-service evaluation time, 30 minutes intra-service time, 30 minutes post-service time, and 100 minutes total time as supported by the survey. The RUC established that there is no duplication of work, as an Evaluation and Management (E/M) service would typically be reported with 38228 in the facility setting and confirmed that it is typical to treat only one patient per day.

To justify a work RVU of 3.00, the RUC compared CPT code 38228 to the top key reference service code 38241 *Hematopoietic progenitor cell (HPC); autologous transplantation* (work RVU = 3.00, 60 minutes intra-service time and 108 minutes total time) and discussed that the intra-service time is twice that of the surveyed code with similar total time, yet the surveyed code is much more intense, justifying the same value for the two codes. CAR-T services exhibit heightened intensity attributable to various factors. The CAR-T cell product is characterized by its diminutive size, exorbitant cost, and substantial scarcity, rendering its acquisition a formidable endeavor. Patients and healthcare providers invest significant time, spanning weeks or even months, in preparation for the administration of this product. Consequently, the intrinsic value of the cellular infusion is imbued with a sense of preciousness. In stark contrast to the reference code, wherein donors can be approached for additional contributions under appropriate circumstances, the CAR-T paradigm affords scant opportunities for recourse in the event of product-related mishaps. The surveyed code thus encapsulates the stressors inherent in treating patients in an advanced state of illness, for whom CAR-T therapy represents a last-chance intervention.

The RUC also noted that the median pre-service evaluation time is 40 minutes for the surveyed code compared with 18 minutes for the top key reference service code despite a similar description of pre-service work. The specialties clarified that there are several unique physician activities included in CAR-T services which are novel or more exaggerated in comparison to the key reference codes. These include checking and confirming multiple aspects of the CAR-T product specifications, quality control testing results, and dose. These are more extensive than the checks on the product in the reference code. A baseline Immune effector Cell-Associated Neurotoxicity Syndrome (ICANS) assessment is performed, which is not part of the reference codes. Preparing the patient, staff, pre-medications, and emergency equipment are also performed in advance of product thawing (actual product thawing reported with 38227), since the CAR-T product (unlike the product in the reference codes) has a very short expiration time. This prolongs the pre-time as compared to the reference code since coordination and preparation must be sequential and precisely coordinated.

For additional support, the RUC compared CPT code 38228 to MPC codes 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.29, 25 minutes intra-service time and 35 minutes total time) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50, 40 minutes intra-service time and 70 minutes total time) and noted that the comparison codes appropriately bracket the surveyed code. The RUC concluded that CPT code 38228 should be valued at the 25th and median work RVU as supported by the survey. **The RUC recommends a work RVU of 3.00 for CPT code 38228.**

Practice Expense
For CPT code 38228, no changes were made to the recommended inputs as submitted by the specialty societies. The PE Subcommittee discussed the monitoring time and agreed that 3 hours is typical for this service. **The RUC recommends the direct practice expense inputs for CPT code 38228 as submitted by the specialty societies.**

The RUC determined that the non-facility practice expense RVU for CPT codes 38225-38227 should be contractor-priced. The RUC noted that the specialties could revisit the practice expense if this new technology moves to the physician office setting by submitting a request to CMS to price it in the non-facility.

New Technology
CPT codes 38225-38228 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.

Intra-Abdominal Tumor Excision or Destruction (Tab 6)
David Holtz, MD (ACOG), Jonathan Kiechle, MD (AUA), Charles Mabry, MD (ACS), Don Selzer, MD (ACS), Kelly Tyler, MD (ASCRS), Richard Weiss, MD (APSA)

In May 2023, the CPT Editorial Panel created five new Category I codes to describe the sum of the maximum length of intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s) excised or destroyed. The new codes will replace existing CPT codes 49203, 49204, and 49205 that described tumor excision or destruction based on the size of the single largest tumor, cyst, or endometrioma removed, no matter the number of tumors. The five new Category I codes were surveyed for the September 2023 RUC meeting.

Compelling Evidence
The specialty societies presented compelling evidence to support a change in physician work for excision and destruction of intra-abdominal tumors based on a change in technology and patient population. When current codes 49203-49205 were established in 2008 as a replacement for two legacy codes (pre-1990) that differentiated tumor excision as "simple" or "complex" (49200-49201), the replacement codes 49203-49205 were established to report tumor excision or destruction based on the size of the largest tumor, cyst, or endometrioma removed, no matter the number of tumors removed. As surgical indications, techniques, and technology have advanced, resection of significantly larger tumors and/or numerous small and large tumors is being performed to save and extend lives of patients that were not considered candidates for treatment previously. In the past, peritoneal surface malignancies (PSM) were considered orphan diseases with limited therapeutic options and a poor prognosis. The primary reasons for poor patient outcomes were related to diagnosis at an advanced stage and the limited clinical response of most entities to conventional therapeutic options such as systemic chemotherapy. Major innovations over the past two decades include the adoption of novel surgical techniques, such as complete cytoreduction (defined as absence of macroscopic disease), and the application of intraperitoneal chemotherapy to address microscopic

residual disease. Despite the perception of high morbidity of such procedures, optimization of perioperative care has led to the morbidity and mortality rates of these procedures being equivalent to those of other major abdominal cancer surgeries. Concurrent development of new multidisciplinary strategies involving perioperative systemic chemotherapy and targeted and maintenance therapies has dramatically changed the landscapes and the prognoses of these diseases. In selected patients, long-term survival and even cure have become possible, and the overall prognosis seems to be equivalent to that of patients with metastatic disease at other sites (such as in the liver or the lungs). In addition, regardless of the underlying origins, the two main prognostic factors for curative management of PSMs are the completeness of cytoreductive surgery (CRS) and the extent of peritoneal disease. Cytoreduction of macroscopic tumors represents a greater amount of work, particularly when dealing with very large tumors and an increased burden of associated macroscopic tumors compared to a single tumor measuring 10-15 cm. Several factors contribute to the increased workload, including the need for more time, physical effort, assessment of resectability, involvement of adjacent structures, and collaboration with additional surgical teams or specialties. **The RUC accepted compelling evidence based on a change in technology and patient population.**

49186 ***Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less***

The RUC reviewed the survey results from 52 surgeons and recommends a work RVU of 22.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 15 minutes scrub/dress/wait time, 150 minutes intra-service time, and 30 minutes immediate post-service time, 1-99232 and 2-99231 hospital visits, 1-99238 discharge day management visit, 1-99214 and 2-99213 office visits, and 442 minutes total time. The RUC agreed that the pre-service work involved a difficult patient and difficult procedure given that patients typically have a malignant neoplastic process which leads to systemic symptoms and eventual diagnosis.

Intraoperatively, an abdominal incision is made that is large enough to allow evaluation of the entire abdominal cavity The peritoneal cavity is entered, adhesions are cleared to expose the abdominal area, and a manual exploration of the abdominal cavity is completed. The surrounding anatomy is carefully palpated for any additional disease, infection, malignancy, or mass. After the extensive manual palpation exploration of the abdomen is complete, the self-retaining retractor is carefully inserted while avoiding injury to surrounding anatomy. The primary mass location is confirmed, and the surrounding anatomy is packed away for optimal exposure. The mass is tediously resected while avoiding division of the blood supply to the corresponding organ. The abdominal cavity is irrigated copiously with antibiotic solution, hemostasis is obtained, the cavity is inspected for injury and presence of instruments, the retractor is removed, and the organs are returned to normal anatomical position. The omentum is placed over the abdominal contents, drain(s) are placed, the fascia is closed, supplies are re-counted, and the subcutaneous tissues are irrigated and closed.

The RUC accepted that 3 post-operative inpatient visits as indicated by the survey respondents are appropriate for this tumor burden size to allow for the restoration of proper bowel function, nutrition intake, pain control, and appropriate recovery of wounds, drains, and incisions. Further imaging is also often required. Additionally, the specialty societies indicated that the number and level of office visits are appropriate based on the level of medical decision making required for one or more chronic illnesses with exacerbation, the continuation of working toward the treatment goal, review of pathology reports, coordination of care with oncologists, and management of postoperative pain. The RUC agreed with the typical post-operative care given the clear need for continuous assessment of the treatment plan for an optimal patient outcome.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 22905 *Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater* (work RVU = 21.58, 150 minutes intra-service, 463 minutes total time) and 27059 *Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater* (work RVU = 29.35, 220 minutes intra-service, 608 minutes total time). Survey respondents indicated that the surveyed code was somewhat more, to much more intense and complex when compared to codes 22905 and 27059. The slightly higher complexity of the surveyed code is due to the increased depth and breadth of intraperitoneal exploration to identify and excise not only a single large tumor, but also to inspect peritoneal surfaces and the abdominal contents for any additional smaller tumors that may not have shown up on preoperative imaging. This adds psychological stress and requires more mental effort and judgment to confirm excision and destruction of all macroscopic tumors. Paired with this increased complexity and the intra-service and total time when compared with the key reference services, the surveyed code is appropriately valued at the recommended work RVU of 22.00.

For additional support, the RUC compared the surveyed code to MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service, and 404 minutes total time). The MPC code requires less intra-service time and total time providing support that the surveyed code is valued appropriately higher. **The RUC recommends a work RVU of 22.00 for CPT code 49186.**

49187 ***Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5.1 to 10 cm***

The RUC reviewed the survey results from 48 surgeons and recommends a work RVU of 28.65 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 15 minutes scrub/dress/wait time, 195 minutes intra-service time, and 30 minutes immediate post-service time, 1-99233, 1-99232, and 2-99231 hospital visits, 1-99238 discharge day management visit, 1-99214 and 2-99213 office visits, and 542 minutes total time. Similar to the first code in this family, the RUC agreed that the pre-service work related to a difficult patient and difficult procedure were appropriate given that patients typically have a malignant neoplastic process which leads to systemic symptoms and eventual diagnosis.

For code 49187, the intra-service work is similar to code 49186, however, additional exploration and additional excision and destruction of additional tumor burden is performed, including macroscopic tumor deposits on parietal, omental, and peritoneal surfaces and small lesions and multiple surface nodules of the omentum, visceral, and peritoneal surfaces. Lastly, given the increase in the tumor(s) or cyst(s) size, the incision is larger and the tumor excision becomes more tedious given the complexities of the surround anatomy. This also factors into the post-operative work and additional hospital inpatient care when compared with the typical postoperative stay for patients undergoing 49186.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 27059 *Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater* (work RVU = 29.35, 220 minutes intra-service, 608 minutes total time) and 22905 *Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater* (work RVU = 21.58, 150 minutes intra-service, 463 minutes total time). Survey respondents indicated that the surveyed code was somewhat more, to much more intense and complex when compared to codes 27059 and 22905. Given that the same surgeons perform 27059 and 22905, they are optimal comparators to determine the relative intensity and complexity of the surveyed code. For example, the higher intensity and complexity of the surveyed code is due to the increased breadth of intraperitoneal

exploration to identify and excise not only multiple implants identified preoperatively, but also to inspect the bowel and abdominal organs for any additional tumors that may not have shown up on preoperative imaging. This adds psychological stress and requires more mental effort and judgment, which supports a slightly higher level of complexity to perform the surveyed procedure. Given this increased complexity and the intra-service and total time when compared with the key reference services, the surveyed code is appropriately valued at the recommended work RVU of 28.65.

For additional support, the RUC compared the surveyed code to MPC code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service, and 512 minutes total time). MPC code 34705 requires less intra-service and total time, although is slightly more complex and therefore, the surveyed code is valued slightly lower at a work RVU of 28.65. The RUC also compared the survey code to MPC code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 25.18, 198 minutes intra-service, and 466 minutes total time). Although MPC code 55845 has almost the same intraoperative time and a similar intraoperative intensity, 55845 requires significantly less postoperative work and therefore has a lower work RVU. **The RUC recommends a work RVU of 28.65 for CPT code 49187.**

49188 ***Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 10.1 to 20 cm***

The RUC reviewed the survey results from 47 surgeons and recommends a work RVU of 34.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 50 minutes of pre-service evaluation time, 8 minutes positioning time, 15 minutes scrub/dress/wait time, 240 minutes intra-service time, and 30 minutes immediate post-service time, 2-99233, 299232, 1-99231 hospital visits, 1-99239 discharge day management visit, 1-99214 and 3-99213 office visits, and 717 minutes total time. The RUC accepted that an additional 10 minutes of evaluation time appropriately accounts for atypical extensive preoperative review of angiograms, MR, and CT imaging and reports to assist with preoperative planning. The abdomen cannot be marked for lesion excision, and instead, imaging must be reviewed and available to appropriately sequence the exploration and excision and destruction of tumors. The RUC also accepted that additional positioning time was appropriate to account for lithotomy positioning so that the surgeon can explore all areas of the intra-abdominal cavity throughout the procedure.

The intraoperative work of 49188 is more extensive than for 49186 and 49187. The increased tumor excision and destruction factors into the postoperative work and additional hospital inpatient care when compared with the postoperative stay for patients undergoing 49186 or 49187. As more tumors and peritoneal stripping is performed, there is increased peritoneal swelling and fluid shift, significant pain, prolonged GI dysfunction requiring modulation of nutrition, and a need for close monitoring of labs--all requiring a longer and more intensive hospital stay.

The RUC agreed with the specialties that the final facility exam and discharge management for the typical patient will require more time and work which is consistent with 99239. These patients will all be going home weak from surgery and require continued prophylaxis for DVT, and coordination with home health care providers for nutrition, therapy and drain management, and coordination with other providers regarding initiation of preoperative medications chronic disease. The RUC also agreed with

the specialties that the number and level of postoperative office visits was appropriate and supported by medical decision making and time.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 47780 *Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract* (work RVU = 42.32, 240 minutes intra-service, 799 minutes total time) and 27059 *Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater* (work RVU = 29.35, 220 minutes intra-service, 608 minutes total time). The surveyed code is bracketed appropriately by the key reference services given the similar intra-service times and the surveyed code total time that falls appropriately in the middle of the key reference services justifying the recommended work RVU of 34.00.

For additional support, the RUC compared the surveyed code to MPC codes 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service, 512 minutes total time) and 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts* (work RVU = 39.88, 193 minutes intra-service, 717 total time). MPC code 34705 requires less intraoperative time and less postoperative work and is appropriately less than 49188. MPC code 33534 requires less intraoperative time, but significantly more and higher level postoperative work and is appropriately valued higher than 49188. The MPC codes therefore appropriately bracket the surveyed code. Therefore, the recommended work RVU of 34.00 is justified and maintains relativity within the code family and within the MPS. **The RUC recommends a work RVU of 34.00 for CPT code 49188.**

49189 ***Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm***

The RUC reviewed the survey results from 46 surgeons and recommends a work RVU of 45.00 based on the survey median percentile, which maintains relativity within the family for this code. The RUC recommends 50 minutes of pre-service evaluation time, 15 minutes positioning time, 15 minutes scrub/dress/wait time, 310 minutes intra-service time, and 30 minutes immediate post-service time, 2-99233, 2-99232, 2-99231 hospital visits, 1-99239 discharge day management visit, 1-99214 and 3-99213 office visits, and 814 minutes total time. The RUC accepted that an additional 10 minutes of evaluation time appropriately accounts for atypical extensive preoperative review of angiograms, MR, and CT imaging and reports to assist with preoperative planning. The abdomen cannot be marked for lesion excision, and instead, imaging must be reviewed and available to appropriately sequence the exploration and excision and destruction of tumors. The RUC also accepted that additional positioning time was appropriate to account for initial lithotomy positioning and repositioning as needed to gain access to all areas of the peritoneal and retroperitoneal space during the 5+ hour procedure.

The intraoperative work of 49189 is more extensive than for 49186, 49187, and 49188. The increased tumor excision and destruction factors into the postoperative work and additional hospital inpatient care when compared with the postoperative stay. As more tumors and peritoneal stripping is performed, there is increased peritoneal swelling and fluid shift, significant pain, prolonged GI dysfunction requiring modulation of nutrition, and a need for close monitoring of labs--all requiring a longer and more intensive hospital stay.

The RUC agreed with the specialties that the final facility exam and discharge management for the typical patient will require more time and work which is consistent with 99239. These patients will all be going home weak from surgery and require continued prophylaxis for DVT and coordination with home health care providers for nutrition, therapy and drain management, and coordination with other providers regarding initiation of preoperative medications chronic disease. The RUC also agreed with the specialties that the number and level of postoperative office visits was appropriate and supported by medical decision making and time.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 58240 *Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof* (work RVU = 49.33, 420 minutes intra-service, and 1,118 minutes total time) and 47780 *Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract* (work RVU = 42.32, 240 minutes intra-service, 799 minutes total time). Survey respondents indicated that the surveyed code was somewhat more, to much more intense and complex when compared to code 58240. Further, the survey respondents indicated that the surveyed code was identical to more intense and complex when compared to code 47780. Therefore, the surveyed code is bracketed appropriately by the key reference services given that the intra-service time falls relatively in the middle with the total time slightly higher than code 47780. However, the complexity to perform the surveyed code is slightly higher than both key references services offering support that the surveyed code recommended work RVU of 45.00 is appropriate.

For additional support, the RUC reviewed similar 090-day global codes that were reviewed in the last 15 years with an intra-service time between 300-320 minutes and found that the recommended work RVU of 45.00 falls at the bottom of the values for similar services. The RUC recognized that the survey 25th percentile would be too low for the complexity and intensity of this procedure and that the median work RVU would more appropriately value 49189 relative to similarly complex and intense procedures. The RUC agreed that the recommended work RVU maintains relativity within the code family and within the MPS. **The RUC recommends a work RVU of 45.00 for CPT code 49189.**

49190 ***Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm***

The RUC reviewed the survey results from 39 surgeons and recommends a work RVU of 55.00 based on the survey median percentile, which maintains relativity within the family for this code. The RUC recommends 60 minutes of pre-service evaluation time, 15 minutes positioning time, 15 minutes scrub/dress/wait time, 360 minutes intra-service time, and 40 minutes immediate post-service time, 5-99233, 2-99232, 1-99231 hospital visits, 1-99239 discharge day management visit, 2-99214 and 2-99213 office visits, and 1,046 minutes total time. The RUC accepted that an additional 20 minutes of evaluation time appropriately accounts for atypical extensive preoperative review of angiograms, MR, and CT imaging and reports to assist with preoperative planning for this procedure that would typically require two surgeons who will typically be of different specialties to access the extensive peritoneal and retroperitoneal examination to locate and excise tumor implants. Additionally, multidisciplinary discussion between the surgeons and with anesthesia requires significantly more time. The RUC also accepted that additional positioning time was appropriate to account for initial lithotomy positioning and repositioning as needed to gain access to all areas of the peritoneal and retroperitoneal space during the 6+ hour procedure.

The intraoperative work of 49190 is more extensive than for the other codes in this family. The increased tumor excision and destruction factors into the postoperative work and additional hospital inpatient care when compared with the postoperative stay. As more tumors and peritoneal stripping is performed, there is increased peritoneal swelling and fluid shift, significant pain, prolonged GI dysfunction requiring modulation of nutrition, and a need for close monitoring of labs--all requiring a longer and more intensive hospital stay. These patients will be very weak and very sick for many days after this procedure and require very close monitoring.

The RUC agreed with the specialties that the final facility exam and discharge management for the typical patient will require more time and work which is consistent with 99239. These patients will all be going home weak from surgery and require continued prophylaxis for DVT and coordination with home health care providers for nutrition, therapy and drain management, and coordination with other providers regarding initiation of preoperative medications chronic disease. The RUC also agreed with the specialties that the number and level of postoperative office visits was appropriate and supported by medical decision making and time.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 43124 *Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy* (work RVU = 69.09, 243 minutes intra-service, 1,398 minutes total time) and 43107 *Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)* (work RVU = 52.05, 270 minutes intra-service, 977 minutes total time). Survey respondents indicated that the surveyed code was somewhat more, to much more intense and complex when compared to codes 43124 and 43107. Although the surveyed code intra-service time is significantly higher than both key reference services, the intraoperative intensity is appropriately similar or slightly less. Therefore, the surveyed code recommended work RVU of 55.00 is bracketed appropriately by the key reference services.

For additional support, the RUC reviewed similar 090-day global codes that were reviewed in the last 15 years with an intra time equivalent to 360 minutes and a total time greater than 900 minutes and found that the recommended work RVU of 55.00 falls at the bottom of the values for similar services. The RUC recognized that the survey 25th percentile would be too low for the complexity and intensity of this procedure and that the median work RVU would more appropriately value 49190 relative to similarly complex and intense procedures. The RUC agreed that the recommended work RVU maintains relativity within the code family and within the MPS. **The RUC recommends a work RVU of 55.00 for CPT code 49190.**

Practice Expense
The Practice Expense (PE) Subcommittee agreed with the specialty societies that there is compelling evidence to support an increase over the aggregate current cost for clinical activities, supplies, and equipment for the deleted CPT codes 49203-49205. The Subcommittee concurred that there is compelling evidence to justify the opportunity for an increase in the inputs based upon evidence of flawed methodology of prior review which was missing required postoperative disposable supplies. The Subcommittee also acknowledged the increase in post-operative office visits. The PE Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

MRI-Monitored Transurethral Ultrasound Ablation of Prostate (Tab 7)
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Facilitation Committee #2

At the April 2023 CPT Editorial Panel meeting, three new CPT codes, 53866, 55881 and 55882, were approved for MRI-monitored transurethral ultrasound ablation (TULSA). Prior to this, the CPT code set did not have codes that reflected the physician work involved in the treatment of planning, insertion and ablation procedures conducted with an MRI-monitored TULSA system, which consists of robotically driven directional thermal ultrasound and closed-loop temperature feedback control software to deliver predictable physician prescribed ablation of prostate tissue. The MRI-monitored TULSA procedure treats patients with prostate cancer while maintaining quality of life due to low rates of adverse events. CPT 53866 and 55881 are reported when the work of the MRI-Monitored TULSA procedure is split, and each component is individually performed by one physician on the same patient. One physician, commonly a urologist, performs the work as defined by CPT 53866 and the other physician, commonly a radiologist, performs the work as defined by CPT 55881. CPT 55882 describes the work when a single physician performs the entire procedure themselves. This code family was surveyed for the September 2023 RUC meeting.

53866 ***Insertion of transurethral ablation transducers for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed***
The RUC reviewed the survey results from 34 urologists and radiologists and recommends a work RVU of 4.05, which is a direct work RVU crosswalk to CPT code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU = 4.05, 30 minutes intra-service time and 79 minutes total time). CPT code 53866 describes MRI-monitored transurethral thermal ultrasound ablation typically performed by a urologist. The RUC recommends 23 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 29 minutes intra-service time, and 15 minutes post-service time, which equals 82 minutes of total time.

The specialty society selected pre-service time package *3-FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Pro.* Both standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. Ten minutes of pre-service evaluation time were removed from the pre-service time package in accordance with the survey time of 23 minutes. Two minutes of pre-service positioning time were also added to the pre-service time package, which is necessary given the use of MRI technology and the importance of positioning to ensure the alignment of the treatment planning images and appropriate placement of the transducer to the intended target match while avoiding any nearby critical structures, which includes the neurovascular bundle, the anal sphincter, and the bladder. Five minutes of pre-service scrub/dress/wait time were removed from the pre-service time package in accordance with the survey time of 10 minutes. Eighteen minutes were removed from the post-service time package in accordance with the survey time of 15 minutes. The RUC agreed with all modifications to both the pre-service and post-service time packages.

The RUC concluded that CPT code 53866 should be valued at a work RVU of 4.05 in accordance with a direct work RVU crosswalk to CPT code 52224 to accurately reflect the physician work involved with this procedure and to maintain rank order with the other services in this code family. For additional support, the RUC referenced MPC code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU = 4.00, 25 minutes intra-service time and 81 minutes total time), which requires similar physician work and time to perform

supporting the RUC recommended work RVU. **The RUC recommends a work RVU of 4.05 for CPT code 53866.**

55881 ***Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation;***
The RUC reviewed the survey results from 37 radiologists and urologists and determined the survey 25th percentile work RVU of 9.80 accurately reflects the physician work necessary to perform this service. CPT code 55881 describes MRI-monitored transurethral thermal ultrasound ablation typically performed by a radiologist. The RUC recommends 40 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, and 27 minutes post-service time, which equals 202 minutes of total time.

The specialty society selected pre-service time package *3-FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Pro.* Both standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. Seven minutes of pre-service evaluation time were added to the pre-service time package, which is necessary to ensure and review the additional preparations of the patient for compliance with MRI protocols that are specific to the procedure, including a full evaluation of imaging exams and review of the patient's clinical and pathological diagnoses. Two minutes of pre-service positioning time were also added to the pre-service time package, which is necessary given the use of MRI technology and the importance of positioning to ensure the alignment of the treatment planning images and appropriate placement of the transducer to the intended target match while avoiding any nearby critical structures, which includes the neurovascular bundle, the anal sphincter, and the bladder. Five minutes of pre-service scrub/dress/wait time were removed from the pre-service time package, which is three minutes less than the survey time to align with the post-service time for CPT code 55882. Six minutes were removed from the post-service time package in accordance with the survey results. The RUC agreed with all modifications to both the pre-service and post-service time packages.

To support the recommended work RVU value of 9.80, the RUC compared the surveyed code to the top key reference services 32994 *Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation* (work RVU = 9.03, 90 minutes intra-service time and 168 minutes total time) and noted that the surveyed code is somewhat less intense than CPT code 32994, but requires 30 more minutes intra-service time, thus is appropriately valued higher. For additional support, the RUC referenced MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes intra-service time and 141 minutes total time) and noted that the high intraoperative intensity offsets the difference in intra-service time, strengthening the comparison between the referenced code and the surveyed code. The RUC concluded that CPT code 55881 should be valued at the 25th percentile work RVU as supported by the survey, as it maintains rank order with the other services in this code family. **The RUC recommends a work RVU of 9.80 for CPT code 55881.**

55882 ***Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducers for delivery of the thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed***
The RUC reviewed the survey results from 37 radiologists and urologists and determined the survey 25th percentile work RVU of 11.50 accurately reflects the physician work necessary to perform this service. CPT code 55882 describes MRI-monitored transurethral thermal ultrasound ablation when a single physician performs the entire procedure. The RUC recommends 50 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 125 minutes intra-service time, and 27 minutes post-service time, which equals 222 minutes of total time.

The specialty society selected pre-service time package *3-FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Pro.* Both standard time packages were modified to more accurately reflect pre- and post-service time involved with this service. Seventeen minutes of pre-service evaluation time were added to the pre-service time package, which is necessary to ensure and review the additional preparations of the patient for compliance with MRI protocols that are specific to the procedure, including a full evaluation of imaging exams and review of the patient's clinical and pathological diagnoses. Two minutes of pre-service positioning time were also added to the pre-service time package, which is necessary given the use of MRI technology and the importance of positioning to ensure the alignment of the treatment planning images and appropriate placement of the transducer to the intended target match while avoiding any nearby critical structures, which includes the neurovascular bundle, the anal sphincter, and the bladder. Six minutes were removed from the post-service time package in accordance with the survey results. Additionally, there are five additional minutes of pre-service scrub/dress/wait time (compared to CPT codes 53866 and 55881) consistent with the survey time and the standard time package, and this is due to a sole physician completing two separate activities in succession, namely setting up the computer software and performing the scrub/dress/wait. The RUC agreed with all modifications to both the pre-service and post-service time packages.

To support the recommended work RVU value of 11.50, the RUC compared the surveyed code to the top key reference services 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 15.00, 120 minutes intra-service time and 199 minutes total time) and to the second highest key reference service 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.97, 120 minutes intra-service time and 208 minutes total time). The RUC recognized that the surveyed requires 5 additional minutes of intra-service time than the two key reference services but is significantly less complex/intense to perform. CPT code 93653 involves electrophysiologic evaluation with catheter ablation, while CPT code 93591 requires percutaneous transcatheter closure of a paravalvular leak, initial device. Thus, a lower work RVU despite the increased intra-service time is appropriate for CPT code 55882.

For additional support, the RUC referenced MPC codes 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes intra-service time and 166 minutes total time) and 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes intra-service time and 141 minutes total time), which appropriately bracket the surveyed code. The RUC concluded that CPT code 55882 should be valued at the 25th percentile work RVU as supported by the survey, as it maintains rank order with the other services in this code family. **The RUC recommends a work RVU of 11.50 for CPT code 55882.**

Practice Expense
The Practice Expense (PE) Subcommittee discussed and approved a new high-cost supply item TULSA-PRO Disposable Kit and a new equipment item TULSA-PRO TDC Cart for CPT codes 55881 and 55882. The PE Subcommittee made one modification to add minutes for the new equipment item to CPT code 53866 as well. An additional modification was made at the RUC table to reduce by 1 the number of caps, masks, and shoe covers (SB001, SB033, SB039) in code 55882 upon receiving confirmation that the code is not intended to be used by co-surgeons.

The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies (i.e., priced more than $500). The RUC makes this recommendation to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools and how the PE formula derives the code-level indirect practice expense in part as a multiple of the code-level direct practice expense inputs when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is inappropriately allocated to the subset of practices performing the service which is subsidized by the broader specialty and all other Medicare providers. If high costs supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services. **The RUC recommends that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
CPT codes 53866, 55881 and 55882 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.

Optical Coherence Tomography (Tab 8)
Charles Fitzpatrick, OD (AOA), David Glasser, MD (AAO), Ravi Parikh, MD (AAO), Ankoor Shah, MD (AAO), John Thompson, MD (ASRS)

At the February 2023 CPT Editorial Panel meeting, CPT code 92137 was created in response to new technology that allows imaging of the retina using optical coherence tomography (OCT) with and without non-dye OCT angiography (OCT-A). This new Category I code describes a combined imaging procedure, which bundles the work currently described by 92134 along with more specific angiography testing which reflects new technology. All four services in this ophthalmic diagnostic imaging code family were reviewed and resurveyed for the April 2023 RUC meeting.

The survey was sent to a random sample of ophthalmologists and optometrists from the three participating specialty societies. In reviewing survey responses for CPT code 92137, it was apparent to the specialty societies that the survey instructions were unclear given the respondents' underestimation of time and misinterpretation of CPT code 92137. The RUC recommended interim recommendations at the April 2023 RUC meeting. Further, the RUC agreed that all four services in the OCT code family should be resurveyed for the September 2023 RUC meeting using a targeted survey instrument that has been reviewed and approved by the Research Subcommittee

92132 ***Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral***
The RUC reviewed the survey results from 75 ophthalmologists, retina specialists, and optometrists and determined a work RVU of 0.29 appropriately accounts for the physician work required to perform CPT code 92132, which is a direct work RVU crosswalk to CPT code 71110 *Radiologic examination, ribs, bilateral; 3 views* (work RVU = 0.29, 6 minutes intra-service time and 8 minutes total time). For this procedure, OCT of the anterior segment is typically performed on patients with the clinical appearance of a shallow anterior chamber or narrow anterior chamber angle to assess the risk of angle closure. The RUC recommends 1 minute pre-service evaluation time, 6 minutes intra-service time, and 1 minute post-service time, which equals 8 minutes of total time. There is only one minute of both pre- and post-service time because this procedure is typically done on the same date of service as an ophthalmological Evaluation and Management (E/M) visit.

To support the recommended work RVU value of 0.29, the RUC compared the surveyed code to the top key reference service 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes intra-service time and 12 minutes total time) and recognized that while the surveyed code has four fewer minutes of intra-service time, it requires greater intra-service intensity to perform than CPT code 99250. For additional support, the RUC referenced MPC codes 74019 *Radiologic examination, abdomen; 2 views* (work RVU = 0.23, 4 minutes intra-service time and 6 minutes total time) and 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32, 7 minutes intra-service time and 9 minutes total time). The RUC determined that using CPT code 71110 as a direct work RVU crosswalk for the surveyed code is appropriate because it accounts for low intra-service time while preserving a higher level of intra-service intensity Furthermore, a work RVU of 0.29 maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.29 for CPT code 92132.**

92133 ***Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve***
The RUC reviewed the survey results from 127 ophthalmologists, retina specialists, and optometrists and determined a work RVU of 0.31 appropriately accounts for the physician work required to perform CPT code 92133, which is a direct work RVU crosswalk to CPT code 71048 *Radiologic examination, chest; 4 or more views* (work RVU = 0.31, 5 minutes intra-service time and 7 minutes

total time). For this procedure, OCT of the optic nerve is typically performed on patients with elevated intraocular pressure (IOP) or glaucoma and is repeated for longitudinal follow-up, typically once a year. The RUC recommends 1 minute pre-service evaluation time, 5 minutes intra-service time, and 1 minute post-service time, which equals 7 minutes of total time. There is only one minute of both pre- and post-service time because this procedure is typically done on the same date of service as an ophthalmological E/M visit.

To support the recommended work RVU value of 0.31, the RUC compared the surveyed code to the second highest key reference service 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes intra-service time and 12 minutes total time) and recognized that while the surveyed code has five fewer minutes of intra-service time, it requires greater intra-service intensity to perform than CPT code 99250. For additional support, the RUC referenced MPC codes 74019 *Radiologic examination, abdomen; 2 views* (work RVU = 0.23, 4 minutes intra-service time and 6 minutes total time) and 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32, 7 minutes intra-service time and 9 minutes total time). The RUC determined that using CPT code 71048 as a direct work RVU crosswalk for the surveyed code is appropriate because it accounts for low intra-service time while preserving a higher level of intra-service intensity. Furthermore, a work RVU of 0.31 maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.31 for CPT code 92133.**

92134 *Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina*
The RUC reviewed the survey results from 151 ophthalmologists, retina specialists, and optometrists and determined a work RVU of 0.32 appropriately accounts for the physician work required to perform CPT code 92134, which is a direct work RVU crosswalk to CPT code 74022 *Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest* (work RVU = 0.32, 5 minutes intra-service time and 7 minutes total time). For this procedure, OCT of the retina is typically performed on patients with wet macular degeneration, diabetic macular edema, or a retinal vascular occlusion to determine the response to intravitreal anti-VEGF (anti-vascular endothelial growth factor) therapy and determine the need for and timing of further intravitreal injections. The RUC recommends 1 minute pre-service evaluation time, 5 minutes intra-service time, and 1 minute post-service time, which equals 7 minutes of total time required to perform this service. There is only one minute of both pre- and post-service time because this procedure is typically done on the same date of service as an ophthalmological E/M visit.

To support the recommended work RVU value of 0.29, the RUC compared the surveyed code to the top key reference service 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes intra-service time and 12 minutes total time) and recognized that while the surveyed code has five fewer minutes of intra-service time, it requires greater intra-service intensity to perform than CPT code 99250. For additional support, the RUC referenced MPC codes 74019 *Radiologic examination, abdomen; 2 views* (work RVU = 0.23, 4 minutes intra-service time and 6 minutes total time) and 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32, 7 minutes intra-service time and 9 minutes total time). The RUC determined that using CPT code 74022 as a direct work RVU crosswalk for the surveyed code is appropriate because it accounts for low intra-service time while preserving a higher level of intra-service intensity. Furthermore, a work RVU of 0.32 maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.32 for CPT code 92134.**

92137 ***Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina including OCT angiography***

The RUC reviewed the survey results from 66 ophthalmologists, retina specialists and optometrists and determined a work RVU of 0.64 appropriately accounts for the physician work required to perform CPT code 92137, which is a direct crosswalk to CPT code 76511 *Ophthalmic ultrasound, diagnostic; quantitative A-scan only* (work RVU = 0.64, 10 minutes intra-service time and 15 minutes total time). For this combined procedure, OCT combined with OCT-A of the retina is typically performed on patients with retinal vascular disease, most often diabetic retinopathy, to allow evaluation or retinal ischemia in addition to retinal thickness and response to intravitreal anti-VEGF therapy. It is also used to evaluate choroidal neovascularization in eyes with possible exudative macular degeneration. The RUC recommends 1 minute pre-service evaluation time, 10 minutes intra-service time, and 2 minutes post-service time, which equals 13 minutes of total time required to perform this service. Like the other codes in this family, this service is typically done on the same date of service as an ophthalmologic E/M visit. There is only one minute of pre-service time, but unlike the other codes in this family, there are two minutes of post-service time attributable to this being a combined procedure wherein the report is longer and takes more time to review.

CPT code 92137 is a combined procedure in that the intra-service work involves the same analysis of the standard OCT images as CPT code 92134, but it also includes the OCT-A component, which entails a comprehensive evaluation of the retinal and choroidal vasculature in the posterior segment for evidence of ischemia, microaneurysms and neovascularization. The RUC concurred that 10 minutes intra-service time was appropriate for the time required to complete both components for the combined study of all OCT and OCT-A images.

To support the recommended work RVU value of 0.64, the RUC compared the surveyed code to the top key reference services 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (work RVU = 0.75, 15 minutes intra-service time and 17 minutes total time) and 92242 *Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral* (work RVU = 0.95, 20 minutes intra-service time and 22 minutes total time). The RUC recognized that while the surveyed code requires 5 minutes less intra-service time compared to the two ophthalmologic top key reference services, CPT code 92134 requires greater intra-service intensity to perform.

For additional support, the RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 76830 *Ultrasound, transvaginal* (work RVU = 0.69, 10 minutes intra-service time and 23 minutes total time). The RUC determined that using CPT code 76511 as a direct work RVU crosswalk for the surveyed code is appropriate because it accounts for low intra-service time while preserving a higher level of intra-service intensity. Furthermore, a work RVU of 0.64 maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.64 for CPT code 92137.**

Practice Expense

At the April 2023 meeting, the Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for the four OCT services in this family and made one modification. An adjustment was made to move the one minute of clinical staff time from CA004 *Provide pre-service education/obtain consent* to CA011 *Provide education/obtain consent* which is the appropriate service period as the patient moves from the screening lane for their first service to the diagnostic

room for the OCT service. The PE Subcommittee verified that the typical service for all four OCT services in this family is bilateral even though the CPT descriptors include both unilateral and bilateral. The Subcommittee also reviewed the new equipment item *tomographic device, optical coherence angiography (OCTA)* for CPT code 92137 and determined that the default formula was appropriate for calculating the equipment minutes. At the April 2023 meeting, the RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee. At the September 2023 meeting, the Practice Expense Subcommittee reviewed and affirmed the direct practice inputs from May 2023 without modification. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

New Technology
CPT code 92137 will be placed on the New Technology list to be reviewed in three years to ensure correct valuation, patient population, and utilization assumptions.

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

Transcranial Doppler Studies (Tab 9)
Melissa Chen, MD (ASNR), Kevin Kerber, MD (AAN), Lauren Nicola, MD (ACR), Jacob Ormsby, MD (ASNR), Charles Tegeler, MD (AAN), Meghan Ward, MD (AAN)

In April 2022, the Relativity Assessment Workgroup (RAW) identified 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 requested action plans for September 2022 to determine if specific code bundling solutions should occur for 93890/93886, 93890/93892, 93892/93886, and 93892/93890. In September 2022, the RAW referred this issue to the CPT Editorial Panel to create a code bundling solution for CPT 2025. The code family was revised at the May 2023 CPT Editorial Panel meeting. Three new add-on codes were created to report when additional studies are performed on the same date of services as a complete transcranial Doppler study (93886). CPT codes 93886, 93888, 93892 and related new/revised codes were surveyed for the September 2023 RUC meeting. CPT code 93890 was deleted as it is not typically clinically appropriate for a vasoreactivity study to be performed independently.

93886 ***Transcranial Doppler study of the intracranial arteries; complete study***
The RUC reviewed the survey results from 38 neurologists, radiologists and neuroradiologists and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the typical physician work involved in this service. The RUC recommends 5 minutes pre-service time, 16 minutes intra-service time and 6 minutes post-service time. This CPT code describes a complete transcranial doppler study, which can assess for underlying abnormalities that could explain the cause of stroke, identify baseline before a subarachnoid patient goes into vasospasm or collateralization pattern in a severe internal carotid artery stenosis to plan surgical options for carotid surgery. A complete transcranial doppler evaluation includes examination of the right and left anterior circulation territories and the posterior circulation territory, including the vertebral arteries and basilar artery.

The specialties noted that due to changes in practice related to increased thrombectomy and other interventional procedures, there is an increased need to identify and evaluate all segments of each vessel, particularly those proximal and distal to lesions following thrombectomy. Interrogation of the

anterior territory via the temporal window is more complicated than the posterior territory via the suboccipital window, because the suboccipital window is both an easier window, not going through the skull, and involves fewer segments. Limited studies now typically include all segments of the right and left anterior territories via the temporal window, leaving out the vertebral and basilar arteries via the suboccipital window. As a result, a limited study that includes both anterior territories finds only a small time savings for both performance and interpretation compared with a study that includes both anterior territories and the posterior territory.

To justify a work RVU of 0.90, the RUC referenced MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81, intra-service time of 11 minutes, total time of 21 minutes) and noted that the survey code involves 5 more minutes of intra-service and 6 more minutes of total time, justifying a higher work value. The RUC also compared the surveyed code to CPT code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography* (work RVU=0.92, intra-service time of 15 minutes, total time of 25 minutes) and noted that the survey code involves slightly more intra-service time and total time and should be valued similarly. The RUC concluded that CPT code 93886 should be valued at the 25th percentile as supported by the survey and favorable comparison to reference codes. **The RUC recommends a work RVU of 0.90 for CPT code 93886.**

93888 ***Transcranial Doppler study of the intracranial arteries; limited study***
The RUC reviewed the survey results from 35 neurologists, radiologists and neuroradiologists and determined that the survey 25th percentile work RVU of 0.73 appropriately accounts for the typical physician work involved in this service. The RUC recommends 5 minutes pre-service time, 15 minutes intra-service time and 5 minutes post-service time.

The specialty noted that the limited study code is reported whenever anything less than all three territories is performed: the left anterior circulation, the right anterior circulation, and the posterior circulation. When this service was last valued, the limited study was typically the posterior circulation. And it is the anterior circulation territories that take up the majority of the time. The specialties noted and the RUC concurred that a limited study now typically includes all segments of the right and left anterior territories via the temporal window, leaving out the vertebral and basilar arteries via the suboccipital window. Interrogation of the anterior territory via the temporal window is more complicated than the posterior territory via the suboccipital window, because the suboccipital window is both an easier window, not going through the skull, and involves fewer segments.

As a result, a limited study that includes both anterior territories typically involves only a small time savings for both performance and interpretation compared with a study that includes both anterior territories and the posterior territory (CPT code 93886). The specialty noted that, although the service is considered "limited" as it involves looking at a subsection of the vascular tree going to the brain, that does not necessarily mean that it involves much less time. If the physician must review more anatomic nuance within different branches of the cerebrovascular system, the "limited" study could still end up being similar time to a complete study.

To justify a work RVU of 0.73, the RUC referenced top key reference code 93880 *Duplex scan of extracranial arteries; complete bilateral study* (work RVU= 0.80, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services involve identical times. The RUC also compared the surveyed code to CPT code 93925 *Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study* (work RVU= 0.80, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services involve identical times. The RUC concluded that CPT

code 93888 should be valued at the 25th percentile as supported by the survey and favorable comparison to reference codes. **The RUC recommends a work RVU of 0.73 for CPT code 93888.**

93892 ***Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection***
The RUC reviewed the survey results from 35 neurologists, radiologists and neuroradiologists and determined that the survey median work RVU of 1.15 appropriately accounts for the typical physician work involved in this service. The RUC recommends 5 minutes pre-service time, 25 minutes intra-service time and 7 minutes post-service time. This service includes monitoring of intracranial vessels to identify spontaneous microembolization. The study typically includes both the right and left middle cerebral arteries in the anterior territory via the temporal window to help show not only the presence of microembolization but also to help with localization of the source. The specialty noted that the physician will review many images or recordings of possible emboli from either side.

Under the prior coding structure, CPT code 93892 was reported 95% of the time with 93886 and 89% of the time with 93890 for CY2021 Medicare claims data. Under the new coding structure, CPT code 93890 is deleted and 93892 can no longer be reported with 93886. Going forward, CPT code 93892 will typically be reported alone and contributes to the 5-minute increase in intra-service time relative to the times that were previously assigned to this code.

To justify a work RVU of 1.15, the RUC referenced CPT code 76883 *Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity* (work RVU= 1.21, intra-service time of 25 minutes, total time of 39 minutes) and noted that both services involve an identical amount of intra-service time and a similar amount of total time. The RUC also compared the surveyed code to CPT code 71270 *Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.25, intra-service time of 18 minutes, total time of 27 minutes) and noted that the survey code involves 7 more minutes of intra-service time and 10 more minutes of total time. The RUC concluded that CPT code 93892 should be valued at the current and survey median work value as supported by the survey and favorable comparison to reference codes. **The RUC recommends a work RVU of 1.15 for CPT code 93892.**

93893 ***Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection***
The RUC reviewed the survey results from 36 neurologists, radiologists and neuroradiologists and determined that the current work RVU of 1.15 appropriately accounts for the typical physician work involved in this service. The RUC recommends 6 minutes pre-service time, 24 minutes intra-service time and 8 minutes post-service time. This CPT code describes shunt detection, which allows identification of right-to-left shunts. Typically, only one temporal window is used to monitor a middle cerebral artery during this procedure.

Under the prior coding structure, CPT code 93893 was reported 53% of the time with 93886 and 30% of the time with 93890 for CY2021 Medicare claims data. Under the new coding structure, CPT code 93890 is deleted and 93893 can no longer be reported with 93886. Going forward, CPT code 93893 will typically be reported alone and contributes to the 4-minute increase in intra-service time relative to the times that were previously assigned to this code.

To justify a work RVU of 1.15, the RUC referenced CPT code 76883 *Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity* (work RVU= 1.21, intra-service time of 25 minutes, total time of 39 minutes) and noted that both services typically involve a

similar amount of intra-service and total time. The RUC also compared the surveyed code to CPT code 71270 *Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.25, intra-service time of 18 minutes, total time of 27 minutes) and noted that the survey code involves 6 more minutes of intra-service time and 11 more minutes of total time. The RUC concluded that CPT code 93893 should be valued at the current work value as supported by the comparison to reference codes. **The RUC recommends a work RVU of 1.15 for CPT code 93893.**

93896 ***Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 30 neurologists, radiologists and neuroradiologists and determined that the survey 25th percentile work RVU of 0.81 appropriately accounts for the typical physician work involved in this service. The RUC recommends 15 minutes intra-service time. A vasoreactivity study includes monitoring of the right and left middle cerebral arteries via the temporal windows during inhalation of carbon dioxide or injection of acetazolamide to evaluate cerebral reserve capacity. CPT code 93890 was deleted as it is not typically clinically appropriate for a vasoreactivity study to be performed independently.

It was noted that although 93896 is being assigned the same amount of time as add-on code 93897, it is an appropriate rank order to assign a slightly higher valuation. It was noted that the typical patient for a vasoreactive study would typically be someone with critical carotid stenosis who experienced some kind of neurologic event and is presumably getting this study to assess their reserve in anticipation of either stenting, or some other therapy that is deemed appropriate. When an embolus appears on a emboli detection study, it is hard to miss. Whereas with a vasoreactive study, detecting a vasospasm is more subtle and a relatively more complex study to perform.

To justify a work RVU of 0.81, the RUC referenced top key reference code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* (work RVU= 0.85, intra-service time of 15 minutes, total time of 15 minutes) and noted that both services typically involve an identical amount of time and a similar overall amount of physician work. The RUC also compared the surveyed code to 2nd key reference code 95984 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)* (work RVU= 0.80, intra-service time of 15 minutes, total time of 15 minutes) and noted that both services typically involve an identical amount of time and a similar overall amount of physician work. The RUC concluded that CPT code 93896 should be valued at the current and survey 25th percentile work value as supported by the survey and favorable comparison to reference codes. **The RUC recommends a work RVU of 0.81 for CPT code 93896.**

93897 ***Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 31 neurologists, radiologists and neuroradiologists and determined that the survey 25th percentile work RVU of 0.73 appropriately accounts for the typical physician work involved in this service. The RUC recommends 15 minutes intra-service time. The specialty noted that there are some time savings when emboli detection is performed as an add-on

related to finding the temporal windows for both the right and the left anterior territories compared to when performed as a standalone since these were already located in the base code. The specialty and the RUC concurred that, although both services typically involve the same amount of physician time, this service is slightly less intense than a vasoreactive study.

To justify a work RVU of 0.73, the RUC referenced top key reference code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* (work RVU= 0.85, intra-service time of 15 minutes, total time of 15 minutes) and noted that although both services typically involve an identical amount of time and a similar overall amount of physician work. The RUC also compared the surveyed code to 2nd key reference code 95984 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)* (work RVU= 0.80, intra-service time of 15 minutes, total time of 15 minutes) and noted that although both services typically involve an identical amount of time and a similar overall amount of physician work. The RUC concluded that CPT code 93897 should be valued at the current and survey 25th percentile work value as supported by the survey and favorable comparison to reference codes. **The RUC recommends a work RVU of 0.73 for CPT code 93897.**

93898 ***Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 31 neurologists, radiologists and neuroradiologists and determined that the survey 25th percentile work RVU of 0.85 appropriately accounts for the typical physician work involved in this service. The RUC recommends 20 minutes intra-service time. The specialty noted that there are some time savings when venous-arterial shunt detection is performed as an add-on service related to finding the window on the side being tested since this was already located in the base code.

To justify a work RVU of 0.85, the RUC referenced top key reference code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* (work RVU= 0.85, intra-service time of 15 minutes, total time of 15 minutes) and noted that although the surveyed code typically involves 5 more minutes of total time, both services should have a similar valuation due to differences in intensity. The RUC also compared the surveyed code to MPC code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU= 0.80, intra-service time of 15 minutes, total time of 15 minutes) and noted that the surveyed code typically involves 5 more minutes of intra-service and total time. The RUC concluded that CPT code 93898 should be valued at the current and survey 25th percentile work value as supported by the survey and favorable comparison to reference codes. **The RUC recommends a work RVU of 0.85 for CPT code 93898.**

Practice Expense
The Practice Expense Subcommittee made two changes to the original proposal submitted by the specialties. For 93893, the Practice Expense Subcommittee removed some of the clinical staff time, as it overlapped a typically performed E/M service on the same day. The Practice Expense Subcommittee also removed CA031 *Review examination with interpreting MD/DO* as that is not

typical for the four base codes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

Hyperthermic Intraperitoneal Chemotherapy (Tab 10)
David Holtz, MD (ACOG), Charles Mabry, MD (ACS), Kelly Tyler, MD (ASCRS)

In September 2022, the CPT Editorial Panel created two time-based add-on Category I codes to report hyperthermic intraperitoneal chemotherapy (HIPEC) procedures for CPT 2024. CPT codes 96547 and 96548 were surveyed for the January 2023 RUC meeting. While reviewing the survey data, it was clear to the specialty societies that the instructions were not sufficient as the survey data reflected time estimates that far exceed the time specified in these new time-based code descriptors. The RUC reached the conclusion that the survey data was flawed due to a lack of work definition and guidelines for reporting these time-based codes. As a result, the RUC recommended contractor pricing for 2024 and also recommended that the two codes be referred to the CPT Editorial Panel for additional clarification. At the May 2023 CPT Editorial Panel meeting new guidelines that describe the activities included in the HIPEC procedure were approved and the codes were re-surveyed for the September 2023 RUC meeting using the standard add-on code RUC survey.

96547 ***Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and recommends a work RVU of 6.53 based on the survey 25th percentile, which maintains relativity within the family for this add-on code. The RUC recommends 60 minutes intra-service and total time for this time-based add-on code.

The HIPEC procedure is reported based on the surgeon's total time for both face-to-face and non-face-to-face activities related to the HIPEC procedure, which may include chemotherapy agent selection, confirmation of perfusion equipment settings for chemotherapy agent delivery, additional incision(s) for catheter and temperature probe placement, perfusion supervision and manual agitation of the heated chemotherapy agent in the abdominal cavity during chemotherapy agent dwell time, irrigation of the chemotherapy agent, closure of wounds related to HIPEC, and documentation of the chemotherapy agent and HIPEC procedure in the medical record. The HIPEC procedure does not include the typical preoperative, intraoperative, and postoperative work related to the primary procedure(s) such as peritoneal tumor resection and cytoreduction. Code 96547 is reported for the first 60 minutes of total time and code 96548 is reported for each additional 30 minutes of total time.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU = 6.50, 60 minutes intra-service and total time) and 34833 *Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 8.16, 72 minutes intra-service and total time). Key reference code and MPC code, 34709, is a

favorable comparator given that both codes typically involve the same amount of time and both also include preoperative planning, intraoperative maneuvers and introduction/removal of additional devices, and postoperative documentation of the add-on work. Overall, the intensity and complexity of both procedures are similar. The surveyed code is valued appropriately lower than the other key reference service 34833 given that the intra-service and total time are lower.

For further support, the RUC compared the surveyed code to an additional MPC code, 34715 *Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 6.00, 60 minutes intra-service and total time). The surveyed code is appropriately valued slightly higher as the HIPEC procedures includes intraoperative treatment of microscopic tumors using a heated chemotherapeutic agent which is significantly more complex and intense than the exposure and closure of a vessel (ie, no treatment) as described by 34715. **Therefore, the RUC recommends a work RVU of 6.53 for CPT code 96547.**

96548 ***Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and recommends a work RVU of 3.00 based on the survey 25th percentile, which maintains relativity within the family for this add-on code. The RUC recommends 30 minutes intra-service and total time for this add-on code. The HIPEC procedure generally lasts between 60-120 minutes. Therefore, it is expected that 1-2 units of this add-on code will be reported when necessary.

The HIPEC procedure is reported based on the surgeon's total time for both face-to-face and non-face-to-face activities related to the HIPEC procedure. Code 96547 is reported for the first 60 minutes of total time and code 96548 is reported for each additional 30 minutes of total time.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 19294 *Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)* (work RVU = 3.00, 40 minutes intra-service and total time) and 44701 *Intraoperative colonic lavage (List separately in addition to code for primary procedure)* (work RVU = 3.10, 35 minutes intra-service and total time). The survey respondents found that the surveyed code was overall more intense/complex than both key reference services. For example, key reference service code 19294 describes preparation of a post-mastectomy cavity to receive a radiation treatment applicator that is placed by a radiation oncologist. This involves additional dissection of the cavity and then suturing the applicator in place. Neither of these activities are as intense or complex as intra-abdominal perfusion, manipulation, and removal of a heated chemotherapeutic agent in an effort to destroy microscopic peritoneal tumors as described by the surveyed code. Further, key reference service code 44701 is similar to the surveyed code as both services are "flushing" an organ (colon and peritoneum, respectively). However, the intensity and complexity for intra-abdominal perfusion, manipulation, and removal of a heated chemotherapeutic agent, is significantly greater for the surveyed code.

For additional support, the RUC compared the surveyed code to MPC code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65, 30 minutes intra-service and total time). The surveyed code is more intense and complex and is

valued appropriately higher than the MPC code 36476 which describes a percutaneous office-based treatment for varicose veins. **The RUC recommends a work RVU of 3.00 for CPT code 96548.**

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

New Technology
CPT codes 96547 and 96548 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.

Telemedicine Evaluation and Management Services (Tab 11)
Amy Ahasic, MD (ATS/CHEST), Patricia Garcia, MD (AGA), Steve Krug, MD (AAP), Lisa Price, MD (AGS), Phillip Rodgers, MD (AAHPM), Korinne Van Keuren, DNP (ANA), Richard Wright, MD (ACC)

During the COVID-19 public health emergency (PHE), there was a need to immediately provide office evaluation and management (E/M) visits via telemedicine. For Medicare patients, the office visits CPT codes 99202-99215 were reported with modifier 95 *Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System* appended to indicate the encounter was performed via telemedicine. Additionally, CPT codes 99441-99443 for telephone E/M services were reported for both new and established patients at the same Medicare payment rate analogous to in-person office E/M visits.

In June 2022, the joint CPT/RUC Telemedicine Office Visits Workgroup was formed to assess available data and recommend the appropriate next steps to determine accurate coding and valuation, as needed, for office E/M visits performed via audio-video and audio-only modalities, beyond the PHE. The Workgroup utilized the following guiding principles:

- Allow enhanced patient access and improve care by use of clear service descriptions and use of a resource-based valuation methodology
- Administratively simple
- Reduce the need for audits
- Provide a single recognized source of coding for telemedicine and audio-only office visits
- There is no direct goal for payment redistribution between specialties

The Workgroup gathered feedback via survey from 70 specialty societies for office visits performed via telemedicine to determine the next steps. Most respondents indicated they use clinical staff in the provision of telemedicine services. Another survey was also conducted to gather information about services provided via audio-only. This information allowed the Workgroup to conclude that separate audio-video and audio-only telemedicine services codes should be developed. The Workgroup submitted a CPT Code Change Application (CCA) for the February 2023 CPT meeting.

In February 2023, the CPT Editorial Panel added a new Evaluation and Management (E/M) subsection for Telemedicine Services. The Panel added 17 codes for reporting telemedicine E/M services as well as new guidelines and notes throughout the new Telemedicine Services subsection. The Panel also deleted three codes (99441-99443) for reporting telephone E/M services and the related guidelines.

Sixteen of the telemedicine E/M codes include eight codes for synchronous audio-video services and eight codes for synchronous audio-only services. Each of these code sets is further split into four codes for new patients and four codes for established patients. These codes may be reported based on the level of medical decision making (MDM) or total time on the date of the encounter, the same as reporting for the in-person office visit codes. For each set of four codes, there is a code that may be reported for a straightforward, low, moderate and high level of MDM. These codes are patterned after the in-person office visit codes, but there is no code that mirrors 99211 because all of the telemedicine codes require the physician or qualified healthcare provider (QHP) to meet with the patient (99211 does not require the presence of a physician or QHP).

In addition, the CPT Editorial Panel established a code for a brief virtual check-in encounter that is intended to evaluate whether a more extensive visit is required. The code descriptor is identical to that of existing HCPCS code G2012 *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion* and is intended to replace that code. The code does not require video technology and is expected to be patient-initiated. It must involve 5-10 minutes of medical discussion. It may not be reported if it originates from a related E/M service furnished within the previous 7 days or if it leads to another E/M or procedure within the next 24 hours or the soonest available appointment. However, if the virtual check-in leads to an E/M in the next 24 hours, and if that E/M is reported based on time, then the time from the virtual check-in may be added to the time of the resulting E/M to determine the total time on the date of encounter for the resulting E/M. Similarly, CPT codes 98008 or 98012 are intended to be reported in lieu of HCPCS code G2252, *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.*

Survey

In April 2023, the RUC noted that the survey instrument did not include the time (when time is used for code selection) in the new telemedicine E/M services descriptors, nor the E/M services displayed on the reference service list (RSL). The RUC made interim recommendations and conducted a new survey for September 2023, which included the minimum required times in the code descriptors, mirroring the office visits (99202-99205, 99212-99215) as approved by the CPT Editorial Panel in May 2023. Also, additional specialties who perform these services participated in the second round of this survey.

To ensure that survey respondents understood the new CPT guidelines and descriptors and the impact that these changes may have on their work, the RUC survey asked that each respondent carefully read the new descriptors/guidelines and attest that they had read the information. The survey respondents understood that code selection will be based on either MDM or time on the date of the patient encounter. When codes are reported based on time, there are specific time requirements within each code descriptor (e.g., 15 minutes must be met or exceeded for 98000).

The CPT time describes the total time devoted to the visit on the day of service (i.e., the sum of synchronous and asynchronous physician or QHP time that day). Importantly, however, the work value for the code is based on the entire time spent by the physician or QHP from three days before the visit to seven days following the visit (that is not described by a separately reportable service). The survey clarified this distinction throughout the survey. The Research Subcommittee approved

capturing the time and work of three days prior and seven days following the telemedicine visits in the survey instrument, which was also used for the survey of in-person office visit services.

The telemedicine E/M services were surveyed by 35 specialty societies and other health care organizations whose physicians and QHPs perform these services. The survey estimates for physician work were similar across all categories of individuals surveyed (medicine, surgery and QHP). The RUC noted that the 25th percentile and median work RVUs reported in the survey were identical for the audio-video telemedicine services, indicating a high degree of consistency in the responses. **The RUC concluded that, in general, in person office visits and audio-video office visits are similar in physician work. Additionally, the RUC concluded that the audio-video and in-person office visits require more physician work than the audio-only office visits.**

Physical Exam

Similar to the in-person office E/M visit codes, the new telemedicine E/M codes only require a medically appropriate history and/or examination. The RUC had an extensive discussion about how a medically appropriate physical examination could be performed via an audio-video or audio-only. To the extent possible via the modality, a physical exam is commonly performed during the telemedicine visit. When MDM is being used for E/M code level selection, code selection is based on the complexity of the problem or problems being addressed, the data being analyzed, points that are considered when making decisions and the risk of the treatment decisions are considered. Alternatively, total physician or QHP time on the date of the encounter is used for code selection.

Most of what a physician or QHP does in terms of chronic management of disease can be accomplished without a traditional physical examination. Some examples of a physical exam performed via telemedicine may be assessing the patient's appearance, gauging if the patient is in any distress, appearance of the patient's skin (pale or well-perfused), clarity of patient's speech, determining if the patient is having trouble breathing, assessing if the patient is confused, hearing the patient's cough and viewing the patient's social/living situation. Additionally, a more focused physical exam in which the patient can assist the physician or QHP could be palpation or percussion of certain parts of the body, range of motion of painful joints, focusing the video capture on a relevant part of the body (e.g., skin lesions, conjunctiva, the back of the throat) and aiding with a neurological exam (e.g. finger to nose testing, or having a family member test the skin sensation of certain body parts).

Audio-Video – New Patient

98000 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***

The RUC reviewed the survey results from 152 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.93 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes total time.

The RUC compared the surveyed code to the top two key reference services and MPC codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93 and 20 minutes total time) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history*

and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. (work RVU = 1.60 and 35 minutes total time). The RUC determined the 98000 was equivalent in physician work to the top key reference code 99202.

For additional support, the RUC referenced MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time). **The RUC recommends a work RVU of 0.93 for CPT code 98000.**

98001 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***

The RUC reviewed the survey results from 175 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 1.60 appropriately accounts for the work required to perform this service. The RUC recommends 36 minutes total time.

The RUC compared the surveyed code to the top two key reference services and MPC codes 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35 minutes total time) and 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time). The RUC determined that the physician work for 98001 was equivalent to the top key reference code 99203.

For additional support, the RUC referenced MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.82, 25 minutes intra-service time and 40 minutes total time). **The RUC recommends a work RVU of 1.60 for CPT code 98001.**

98002 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***

The RUC reviewed the survey results from 187 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 2.60 appropriately accounts for the work required to perform this service. The RUC recommends 58 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35

minutes total time). The RUC determined the surveyed code was equivalent to the top key reference code 99204, as both require the same work and similar time, 58 and 60 minutes total time, respectively.

For additional support, the RUC referenced MPC code 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded* (work RVU = 2.80 and 70 minutes total time). The surveyed code is appropriately lower because it is less intense/complex and requires less physician work and time to perform. **The RUC recommends a work RVU of 2.60 for CPT code 98002.**

98003 ***Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)***

The RUC reviewed the survey results from 172 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 80 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.* (work RVU = 3.50 and 88 minutes total time) and 99483 *Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.* (work RVU = 3.84 and 86 minutes total time). The RUC determined that the physician work for 98003 was equivalent to the top key reference code 99205.

For additional support, the RUC referenced MPC codes 99306 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 3.50 and 80 minutes total time), which requires the same intensity/complexity, physician work and time to perform. **The RUC recommends a work RVU of 3.50 for CPT code 98003.**

Audio-Video – Established Patient

98004 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.***

The RUC reviewed the survey results from 307 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 16 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time) and 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time). The RUC determined that the surveyed code was equivalent to the top key reference code 99212 as both require the same work and time.

For additional support, the RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 0.70 for CPT code 98004.**

98005 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.***

The RUC reviewed the survey results from 357 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 1.30 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time). The RUC determined that the surveyed code was equivalent to the top key reference code 99213 as both require the same work and time.

For additional support, the RUC referenced MPC codes 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) and 70491 *Computed tomography, soft tissue neck; with contrast material(s)* (work RVU = 1.38, 17 minutes intra-service time and 27 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 1.30 for CPT code 98005.**

98006 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***

The RUC reviewed the survey results from 369 physicians and qualified health care professionals and determined that the survey 25th percentile and median work RVU of 1.92 appropriately accounts for the work required to perform this service. The RUC recommends 44 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time) and 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time). The RUC determined that the physician work for 98006 was equivalent to the top key reference code 99214.

For additional support, the RUC referenced MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time) and 72158 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar (work RVU = 2.29 and 35 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 1.92 for CPT code 98006.**

98007 ***Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.***

The RUC reviewed the survey results from 312 physicians and qualified health care professionals and determined that a work RVU of 2.60 appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes total time. The RUC recommends a direct crosswalk to 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time). These services require the same intensity/complexity, work and time to perform. The RUC determined a crosswalk was more appropriate than the survey 25th percentile work RVU of 2.80 since the total time was 10 minutes less than the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the*

encounter for code selection, 40 minutes must be met or exceeded (work RVU = 2.80 and 70 minutes total time).

For additional support, the RUC referenced code 75561 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;* (work RVU = 2.60, 45 minutes intra-service time and 65 minutes total time), which requires the same physician work and similar time to perform. **The RUC recommends a work RVU of 2.60 for CPT code 98007.**

Audio-Only – New Patient

98008 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***

The RUC reviewed the survey results from 88 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93 and 20 minutes total time) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time). The RUC determined that the 25th percentile work RVU of 0.90 is appropriate to validate that this audio-only telemedicine visit requires slightly less work compared to the top key reference code office visit 99202.

For additional support, the RUC referenced MPC code 91111 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report* (work RVU = 0.90 and 25 minutes total time), which requires the same physician work and time to perform. **The RUC recommends a work RVU of 0.90 for CPT code 98008.**

98009 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***

The RUC reviewed the survey results from 92 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 1.55 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 35 minutes total time) and 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded (work RVU = 1.30 and 30 minutes total time). The RUC determined that the survey 25th percentile work RVU of 1.55 is appropriate to validate that this audio-only telemedicine visit requires slightly less work compared to the top key reference code office visit 99203.

For additional support, the RUC referenced MPC code 99304 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.* (work RVU = 1.50 and 36 minutes total time), which requires similar physician work and time to perform. **The RUC recommends a work RVU of 1.55 for CPT code 98009.**

98010 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***

The RUC reviewed the survey results from 98 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 2.42 appropriately accounts for the work required to perform this service. The RUC recommends 51 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time). The RUC noted that the surveyed code requires 9 minutes less than the office visit code 99204 and thus is appropriately valued lower.

For additional support, the RUC referenced MPC code 93312 *Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report* (work RVU = 2.30, 30 minutes intra-service time and 55 minutes total time), which requires less physician work. **The RUC recommends a work RVU of 2.42 for CPT code 98010.**

98011 ***Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)***

The RUC reviewed the survey results from 93 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 3.20 appropriately accounts for the work required to perform this service. The RUC recommends 70 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.* (work RVU = 3.50 and 88 minutes total time) and 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded* (work RVU = 2.80 and 70 minutes total time). The RUC noted that the surveyed code requires 18 minutes less than the office visit code 99205 and thus is appropriately valued lower.

For additional support, the RUC referenced MPC codes 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 2.87, 30 minutes intra-service time and 70 minutes total time) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50 and 70 minutes total time), which appropriately brackets the surveyed code. **The RUC recommends a work RVU of 3.20 for CPT code 98011.**

Audio-Only – Established Patient

98012 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.***

The RUC reviewed the survey results from 262 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 0.65 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time) and 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* (work RVU = 0.18 and 7 minutes total time). The RUC determined that the 25th percentile work RVU of 0.65 is appropriate to validate that this audio-only telemedicine visit requires slightly less work compared to the top key reference code office visit 99212.

For additional support, the RUC referenced MPC codes 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time and 16 minutes total time) and 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 0.65 for CPT code 98012.**

98013 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.***

The RUC reviewed the survey results from 288 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 1.20 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes total time.

The RUC compared the surveyed code to the top two key reference services MPC codes 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30 and 30 minutes total time) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time). The RUC determined that the 25th percentile work RVU of 1.20 is appropriate to validate that this audio-only telemedicine visit requires slightly less work compared to the top key reference code office visit 99213.

For additional support, the RUC referenced MPC codes 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) and 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.35, 20 minutes intra-service time and 30 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 1.20 for CPT code 98013.**

98014 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***

The RUC reviewed the survey results from 270 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 1.75 appropriately accounts for the work required to perform this service. The RUC recommends 41 minutes total time.

The RUC compared the surveyed code to the top key reference service MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time) and 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30 and 30 minutes total time). The RUC noted that the surveyed code requires 6 minutes less than the office visit code 99214 and thus is appropriately valued lower.

For additional support, the RUC referenced MPC codes 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time) and 99460 *Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant* (work RVU = 1.92, 30 minutes intra-service time and 50 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 1.75 for CPT code 98014.**

98015 ***Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)***

The RUC reviewed the survey results from 217 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 2.60 appropriately accounts for the work required to perform this service. The RUC recommends 60 minutes total time.

The RUC compared the surveyed code to the top key reference service MPC codes 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded* (work RVU = 2.80 and 70 minutes total time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* (work RVU = 1.92 and 47 minutes total time). The RUC noted that the surveyed code requires 10 minutes less than the office visit code 99215 and thus is appropriately valued lower.

For additional support, the RUC referenced code 75561 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;* (work RVU = 2.60, 45 minutes intra-service time and 65 minutes total time), which requires the same physician work and similar time to perform. **The RUC recommends a work RVU of 2.60 for CPT code 98015.**

Virtual Check-In

98016 ***Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion***

The RUC reviewed the survey results from 131 physicians and qualified health care professionals and determined that the survey 25th percentile work RVU of 0.30 appropriately accounts for the work required to perform this service. The RUC recommends 14 minutes total time.

The RUC compared the surveyed code to the key reference service MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time) and determined that the surveyed code may require a similar amount of time to perform, but it is much less intense and complex, thus valued lower.

For additional support, the RUC referenced MPC codes 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 3 minutes intra-service time and 6 minutes total time) and 97530 *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes* (work RVU = 0.44, 15

minutes intra-service time and 19 minutes total time), which appropriately bracket the surveyed code. **The RUC recommends a work RVU of 0.30 for CPT code 98016.**

Practice Expense
The Practice Expense Subcommittee reviewed and affirmed the direct practice inputs from May 2023 without modification. The specialty societies surveyed the clinical activities for the telemedicine E/M services and received 182 responses in which 60% of the respondents indicated that the use of clinical staff in the provision of telemedicine E/M services was typical (>50%). The survey directed survey respondents to indicate typical clinical time by CPT code and by clinical activity. The survey included the clinical activities currently included in the direct PE inputs for 99202-99215 as well as an opportunity to write in time and specify additional activities for pre-service period, service period and post-service period. For the survey responses that included clinical staff time, the clinical activity medians were computed and then summed to calculate total time.

In April 2023, the Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. The specialty societies detailed their methodology for making some changes to specific clinical activity codes to adapt them for telemedicine. The specialty societies indicated that only specific clinical activities are applicable and edited CA009 *Greet patient, provide gowning, Ensure appropriate medical records are available*, by deleting "greet patient, provide gowning" and CA013 *Prepare room, equipment and supplies Prepare patient for the visit (i.e., check audio and/or visual),* by deleting "prepare room, equipment and supplies" and adding "prepare patient for the visit (i.e., check audio and/or visual)." The specialty societies explained how they solicited both individual time in each of the clinical activities and total time. The specialty societies also assiduously reviewed each code using the medians for relevant clinical activities and making minor adjustments, so the amount of time for the clinical staff increased appropriately along with the complexity of the medical decision making. In addition, the PE Subcommittee recommends to CMS that a camera and microphone should be considered typical in the computer contained in the indirect overhead expense. The RUC recommends the direct practice expense inputs as submitted by the specialty societies. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

HCPCS Codes
The RUC recommends deletion of G2012 *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion* as this service may be reported using CPT code 98016 in 2025. The RUC also recommends deletion of G2252 *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion* as this service may be reported using CPT codes 98008 or 98012. **The RUC recommends that CMS delete G2012 and G2252.**

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

RUC Flag
The RUC recommends that this family of services be reviewed by the Relativity Assessment Workgroup after three years of data are available.

X. CMS Request/Relativity Assessment Identified Codes

Transcatheter Insertion and Replacement – Permanent Leadless Pacemaker (Tab 12)
Mark Schoenfeld, MD (HRS), David Slotwiner, MD (HRS), Ed Touhy, MD (ACC), Richard Wright, MD (ACC)

In April 2023, the Relativity Assessment Workgroup identified CPT code 33274 via the site of service anomaly screen. Based on Medicare data from 2019-2021 and utilization over 10,000, this service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. The RUC noted that codes 33274 and 33275 were on the April 2023 Workgroup meeting technology/new services list for review. The RUC removed these codes from the new technology/new services list since there was no demonstrated technology diffusion that impacts work or practice expense. The Workgroup questioned the site of service for code 33274 and noted that the RUC valued this service as typically involving an overnight stay that is less than 24 hours in length. However, Medicare claims data shows that 63% are performed in the inpatient hospital setting. The RUC recommended that CPT code 33274 and the relevant family of codes be surveyed for the September 2023 RUC meeting.

In September 2023, the specialty societies indicated that although this service is typically performed in the inpatient setting for Medicare patients, this is not accurate for all patients receiving this service. The specialties indicated that this service was recently reviewed for CPT 2019 and conducting another survey at this time would be premature and result in the same response: that that patient typically stays overnight but less than 24 hours and a half discharge day be applied. These services have not changed since the last review, and based on that data the RUC would not apply a full discharge day.

The specialty societies reported that within the past 60 days, the U.S. Food and Drug Administration (FDA) has granted approval for both atrial and ventricular leadless pacemakers. Atrial leadless pacemakers were not previously available. This development is expected to have a significant impact as many individuals currently receiving lead pacemakers may now receive leadless pacemakers. As a result, there may be a change in the typical patient and physician work associated with these services.

The specialty societies requested, and the RUC agreed, to maintain the current work RVU of 7.80 for CPT code 33274 and 8.59 for CPT code 33275 and for the Relativity Assessment Workgroup to examine these services in three years (September 2026).

Practice Expense
The Practice Expense Subcommittee affirmed the direct practice inputs from January 2018 without modification. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

Ultrasound Elastography (Tab 13)
Robert Kennedy, MD (SIR), Minhajuddin Khaja, MD (SIR), Lauren Nicola, MD (ACR)

In January 2018, the RUC reviewed and submitted recommendations for the ultrasound elastography code family, which describes the physician work involved with assessing organ parenchyma and focal lesions. The purpose of these procedures is to evaluate the degree of scarring within a solid organ,

like the liver, or lesions within solid organs, such as masses within the breast or thyroid. Measuring the stiffness within a solid organ can characterize the severity of parenchymal disease in lieu of performing an invasive procedure to test potential malignancy, such as a biopsy. This code family was flagged for re-review at the April 2023 RUC meeting by the new technology/new services screen. Due to increased utilization of CPT code 76981, the entire code family was resurveyed for the September 2023 RUC meeting.

76981 ***Ultrasound, elastography; parenchyma (eg, organ)***
The RUC reviewed the survey results from 41 diagnostic radiologists and interventional radiologists and determined the survey 25th percentile work RVU of 0.59, which is also the current value, accurately reflects the physician work necessary to perform this service. CPT code 76981 describes the examination and evaluation of a solid organ using elastography imaging. The RUC recommends 5 minutes pre-service evaluation time, 10 minutes intra-service time, and 4 minutes post-service time, which equals 19 minutes of total time. These pre-service and post-service times align with other similar ultrasound and diagnostic radiology codes.

To support the recommended work RVU value of 0.59, the RUC compared the surveyed code to the top key reference service, 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* (work RVU = 0.59, 8 minutes intra-service time and 18 minutes total time) and to the second highest key reference service, 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81, 11 minutes intra-service time and 21 minutes total time) and agreed that both services, with similar intra-service time and comparable physician work, offer accurate comparisons to the recommended work RVU. The RUC recognized that the physician work involved with the surveyed code is similar to that of a limited or complete abdominal ultrasound study as described by the key reference services. While evaluating a patient directly and making clinical judgments using real-time image documentation for an abdominal ultrasound study differs from the physician work performed by a radiologist in measuring the stability or interval changes in organ parenchyma stiffness, the RUC determined it to be an appropriate comparison. Moreover, performing a complete abdominal ultrasound in CPT code 76700 requires more measurements and time; so, the recommended work RVU of 0.59 for the surveyed code is appropriately lower and aligns with the limited abdominal ultrasound study in CPT code 76705 given its lesser intra-service time.

For additional support, the RUC referenced MPC code 76604 *Ultrasound, chest (includes mediastinum), real time with image documentation* (work RVU = 0.59 and 19 minutes total time) and noted that the reference service requires similar physician time as CPT code 76981. The RUC concluded that CPT code 76981 should be valued at the 25th percentile work RVU as supported by the survey, as it maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.59 for CPT code 76981.**

76982 ***Ultrasound, elastography; first target lesion***
The RUC reviewed the survey results from 35 diagnostic radiologists and interventional radiologists and determined the survey 25th percentile work RVU of 0.59, which is also the current value, appropriately accounts for the physician work necessary to perform this service. CPT code 76982 describes the examination and evaluation of a single, specific lesion within a solid organ using elastography imaging. The RUC recommends 5 minutes pre-service evaluation time, 10 minutes intra-service time, and 5 minutes post-service time, which equals 20 minutes of total time.

To support the recommended work RVU value of 0.59, the RUC compared the surveyed code to the top key reference service, 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* (work RVU = 0.59, 8 minutes intra-service time and 18

minutes total time) and to the second highest key reference service 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81, 11 minutes intra-service time and 21 minutes total time) and agreed that both services, with similar intra-service time and comparable physician work, offer accurate comparisons to support the recommended work RVU. The RUC recognized that the physician work involved with the surveyed code is similar to that of a limited or complete abdominal ultrasound study. While evaluating a patient directly and making a clinical judgment using real-time image documentation for an abdominal ultrasound sound study differs from the physician work a radiologist conducts in measuring the stability or interval changes in the stiffness of a focal lesion within a solid organ, the RUC found this to be an appropriate comparison. Moreover, performing a complete abdominal ultrasound, code 76700, requires more measurements and time; so, the recommended work RVU of 0.59 for the surveyed code is appropriately lower and aligns with the limited abdominal ultrasound study in CPT code 76705 given its lesser intra-service time.

For additional support, the RUC referenced MPC code 76604 *Ultrasound, chest (includes mediastinum), real time with image documentation* (work RVU = 0.59 and 19 minutes total time) and noted that the reference service requires similar physician time as CPT code 76982. The RUC concluded that CPT code 76982 should be valued at the 25th percentile work RVU as supported by the survey, as it maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.59 for CPT code 76982.**

76983 ***Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 34 diagnostic radiologists and interventional radiologists and determined the survey 25th percentile work RVU of 0.47, which is lower than the current work RVU of 0.50, appropriately accounts for the physician work required to perform this service. CPT code 76983 is an add-on code describing the examination and evaluation of each additional target lesion within a solid organ using elastography imaging. The RUC recommends 9 minutes intra-service time, which also represents the total time.

To support the recommended work RVU value of 0.47, the RUC compared the surveyed code to the top key reference service, 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU = 0.83 and 10 minutes intra-service and total time) and to the second highest key reference service, 93319 *3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)* (work RVU = 0.50 and 20 minutes intra-service time and total time).

For additional support, the RUC referenced MPC codes 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes intra-service time and total time) and 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00 and 10 minutes intra-service time and total time), The RUC concluded that CPT code 76983 should be valued at the 25th percentile work RVU as supported by the survey, as it maintains rank order with the other existing services in this code family. **The RUC recommends a work RVU of 0.47 for CPT code 76983.**

Practice Expense
The Practice Expense Subcommittee noted that the specialties are recommending the current existing direct practice expense inputs for CPT codes 76981-76983 and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

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

CT Guidance Needle Placement (Tab 14)
Robert Kennedy, MD (SIR), Minhajuddin Khaja, MD (SIR), Lauren Nicola, MD (ACR)

CPT code 77012 was last reviewed by the RUC in April 2017. Subsequently, a CPT code bundling lung biopsy with image guidance was created in February 2019. The CPT Editorial Panel approved the replacement of CPT code 32405 with the new code 32408 to describe lung needle biopsy, including imaging guidance. Following the April 2019 RUC meeting, the specialty society was to submit a request to the Research Subcommittee to modify the vignette for CPT code 77012 to reflect a typical patient who is not a lung biopsy patient. In June 2019, the Research Subcommittee noted that the current vignette for CPT code 77012 describes a patient with a suspicious lung nodule, which reflected the most common diagnostic code in the latest claims data. Since there was no clear dominant diagnosis code once patients with lung nodules are removed, and the next four most common diagnostic codes each represent a similar percentage of the claims (between 4.04 and 4.88%), the specialty proposed to defer updating this vignette for three years to allow time for utilization data to accrue on the new patient population for 77012. The RUC agreed that the specialty societies could wait until after utilization data for the new patient population became available and survey for September 2023. The Research Subcommittee created the new vignette on its May 22, 2023, call.

77012 ***Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation***
The RUC reviewed the survey results from 173 interventional radiologists and diagnostic radiologists and determined that maintaining the current work RVU of 1.50, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends 15 minutes of pre-service evaluation time, 35 minutes intra-service time and 5 minutes immediate post-service time, for 55 minutes total time. It was noted that the median survey times are recommended for the pre-service and intra-service times while the recommended post-service time of 5 minutes is equal to the current time and lower than the survey.

To justify a work RVU of 1.50, the RUC compared CPT code 77012 to the top key reference service code 10007 *Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion* (work RVU = 1.81, 27 minutes intra-service time and 47 minutes total time) and noted that the intra-service and total time for the reference code is less than the surveyed code, yet the reference service is a bundled code that also includes in the work of the procedure, justifying a higher value for key reference service. The RUC also compared the surveyed code to the second key reference code 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* (work RVU = 1.46, 20 minutes intra-service time and 39 minutes total time) and noted that although the reference code is a bundled code, the radiological supervision and interpretation surveyed code describes an imaging modality (CT) that is typically used for longer and more intense image-guided procedures. The surveyed code involves much more intra-service and total time, therefore justifying a higher value. The RUC recommendation is bracketed by the top two key reference services. CPT code 77012 includes more time inherent to the CT modality, however, some of the combined work is less intense than the

bundled FNA procedure codes with either ultrasound or fluoroscopic guidance. This is reflected in the higher intensity for CPT codes 10005 and 10007. Given these differences in intensity, the recommended work RVU for CPT code 77012 maintains relativity with a value slightly higher than CPT code 10005 and lower than CPT code 10007.

For additional support, the RUC compared CPT code 77012 to MPC codes 92014 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits* (work RVU = 1.42, 24 minutes intra-service time and 37 minutes total time) and 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54, 29 minutes intra-service time and 49 minutes total time) and noted that 77012 compares well with the two non-radiology MPC codes. Code 92014 has less intra-service and total time, and a slightly lower work value than the surveyed code while code 95861 has a slightly higher work value, but lower total time than the surveyed code. Both MPC comparisons are associated with slightly more intense work than the CT guidance code for needle placement. Accounting for the survey times and intensity differences, the recommended work value is appropriately bracketed between the comparator codes. The RUC concluded that the value of CPT code 77012 should be maintained at 1.50 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 1.50 for CPT code 77012.**

Practice Expense
The Practice Expense (PE) Subcommittee approved the PE compelling evidence argument that CMS applied a flawed methodology in its assignment of 9 minutes of CT room time. In April 2017, the RUC approved 28 minutes for CT room time for CPT code 77012, applying the highly technical formula. However, in the 2019 MPFS, CMS reduced the room time to 9 minutes, applying the angiographic room time allocation convention, which assigns 9 mins for radiologic supervision and interpretation (RS&I) codes. Angiography procedures are structured to include room time (e.g., CPT code 36247); therefore, it is appropriate for the angiography RS&I codes (e.g., 76726) to only have an additional 9 minutes of room time. In contrast, non-angiography procedures can be reported with or without CT guidance. For CMS to apply the angiography room time convention to the CT guidance code describing a different imaging modality is inappropriate, as CT procedure codes do not contain room time. CPT code 77012 is most commonly performed with procedure code 38222 *Diagnostic bone marrow; biopsy(ies) and aspiration(s)* which does not include CT room time. Only assigning 9 minutes to CT guidance is an underestimation of utilization for this code; the procedure described by 38222 typically has 30 minutes of cut-to-close time. The RUC agreed that application of the highly technical formula is most appropriate, resulting in the recommended 26 minutes for EL007 *room, CT*.

The PE Subcommittee reviewed the direct practice expense inputs and made no modifications. The specialty recommended, and the RUC agreed, to a change in clinical staff type from L041B *Radiologic Technologist* to a L046A *CT Technologist*. When this code was created (formerly CPT code 76360), the clinical staff was identified as a radiology technologist; however, the required technical proficiency for this CT-guided procedure is out of scope for a radiologic tech. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

<u>Annual Alcohol Screening (Tab 15)</u>
Brad Fox, MD (AAFP), Charles Hamori, MD (ACP), Len Lichtenfeld, MD (ACP)

In April 2022, the Relativity Assessment Workgroup identified services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020, including codes G0442 and G0443. In September 2022, the RUC recommended that these services be surveyed for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.

CMS covers the annual alcohol screening service once per year (G0442). For patients who screen positive, CMS covers up to four brief face-to-face behavioral counseling interventions (G0443) for Medicare beneficiaries. Both services are typically performed during an annual wellness visit (AWV) (codes G0438 or G0439) and/or an office visit service For G0442, clinical staff will typically assist the patient in completing the screening tool. Medicare does not define what screening instrument should be used, and there are several that are commonly used. The typical work of the physician for G0442 is to review the collected responses, make sure it is appropriate in the electronic medical record, probe for any follow-up questions, and make an assessment based on the information collected.

The specialty societies surveyed alcohol screening and counseling codes G0442 and G0443 for the April 2023 RUC meeting but did not obtain the required number of survey responses. The RUC recommended the specialty societies work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify physicians and other qualified healthcare professionals who predominantly perform G0442 and/or G0443 and match them with societies to survey those individuals. The specialty societies were also encouraged to expand their random survey sample to other sections of their membership that are more likely to perform these services. As a result, the specialty societies continued to collect survey responses for the September 2023 RUC meeting and worked with the Research Subcommittee to identify a targeted survey sample in addition to an expanded random sample. The specialties were successful in exceeding the minimum number of survey responses for each code for the September 2023 RUC meeting.

Compelling Evidence
The current value for CPT code G0443 is a CMS/Other source, which reflects a value CMS independently assigned from CPT code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU= 0.45, intra-service time of 15 minutes, total time of 17 minutes). CPT code 97803 is performed by registered dieticians/nutrition professionals 100% of the time and is a time-based code that can be reported multiple times (2021 Medicare claims had a median of 2 units for this code). CPT code G0443 has never been reviewed by the RUC and the direct crosswalk code is not performed by physicians. Thus, the specialty societies indicated, and the RUC agreed, that there is compelling evidence that CPT code G0443 is currently based on flawed methodology.

G0442 ***Annual alcohol misuse screening, 5 to 15 minutes***
The RUC reviewed the survey results from 74 family medicine physicians, internal medicine physicians, and nurse practitioners and determined that the survey 25th percentile and current work RVU of 0.18 appropriately accounts for the typical physician work involved in this service. The RUC recommends 5 minutes of intra-service and total time. As described above, G0442 is only covered once per year and is typically billed with an AWV or office visit. The typical work of the physician for G0442 is to review the collected responses, make sure it is appropriate in the electronic medical record, probe for any follow-up questions, and make an assessment based on the information collected. As G0442 is typically performed with an E/M service, the RUC ensured that the time and work valuation is separate and distinct from same-day E/M services. Therefore, the RUC does not recommend any pre-service or post-service time for this code.

To justify a work RVU of 0.18, the RUC referenced the second top key reference code 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* (work RVU= 0.18, total time of 7 minutes) and noted that although the reference code has two more minutes of physician time, 99211 does not require the presence of a physician or other qualified healthcare professional and is a less intense service.

The RUC also compared the surveyed code to CPT code 70250 *Radiologic examination, skull; less than 4 views* (work RVU= 0.18, intra-service time of 3 minutes, total time of 5 minutes) and noted that although the reference code typically involves two minutes less of intra-service time, both services typically involve the same amount of total time and should have a similar valuation. The RUC concluded that CPT code G0442 should be valued at the 25th percentile and current work RVU as supported by the survey and comparison codes. **The RUC recommends a work RVU of 0.18 for CPT code G0442.**

G0443 ***Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes***
The RUC reviewed the survey results from 59 family medicine physicians, internal medicine physicians and nurse practitioners and determined that the survey 25th percentile work RVU of 0.60 appropriately accounts for the typical physician work involved in this service. The RUC recommends 10 minutes of intra-service time and 4 minutes of post-service time.

For patients who screen positive (G0442), CMS covers up to four brief face-to-face behavioral counseling interventions (G0443) for Medicare beneficiaries. Both services are typically performed during an annual wellness visit and/or an office visit service. As G0443 is typically performed with an E/M service, the RUC ensured that the time and work valuation are separate and distinct from same-day E/M services and therefore is not recommending any pre-service time. The distinct work includes discussing the frequency of alcohol use, negative health and social consequences, and overall severity. Clinically appropriate goals are developed and follow-up is discussed.

To justify a work RVU of 0.60, the RUC referenced top key reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU= 0.70, total time of 16 minutes) and noted that 99212 typically involves 2 more minutes of total time, and therefore it is appropriate to assign a slightly lower valuation to the survey code as both services involve a similar intensity of physician or other qualified healthcare professional work.

The RUC also compared the surveyed code to 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.* (work RVU= 0.61, intra-service and total time of 15 minutes) and noted that although the reference code involves somewhat more intra-service time, it is a less intense service as the physician or other qualified healthcare professional is directing clinical staff for the reference code instead of performing the service themselves. The reference code involves only one more minute of total time. The RUC concluded that CPT code G0443 should be valued at the 25th percentile as supported by the survey and comparison codes. **The RUC recommends a work RVU of 0.60 for CPT code G0443.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed and affirmed the direct practice inputs from April 2023 without modification. At the April 2023 meeting, the PE Subcommittee reviewed the proposed direct practice expense inputs and made several modifications. For the clinical labor in G0442, the PE

Subcommittee reduced CA021 *Perform procedure/service---NOT directly related to physician work time* to five minutes as the typical time for the clinical staff to administer the screening tool. For G0443, all clinical staff time was removed for this counseling service since the counseling is performed by a physician or other qualified healthcare professional. The materials distributed to the patient were changed to the typical number of 10 pages to be printed out, SK057 *paper, laser printing (each sheet)* for G0442 and a full SK062 *patient education booklet* for G0443. The equipment minutes were also modified to equal the sum of clinical staff time plus the physician/QHP time as reflected by the survey median. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

Annual Depression Screening (Tab 16)
Charles Hamori, MD (ACP), Amber Isley, MD (AAFP), Len Lichtenfeld, MD (ACP)

Effective October 14, 2011, a new HCPCS code, G0444 *Annual depression screening, 5 to 15 minutes* was added to the Medicare Physician Payment Schedule (MFS) to report annual depression screening for adults in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, treatment and follow up. This service is typically reported with an Evaluation and Management (E/M) service or an Annual Wellness Visit (codes G0438 or G0439). The current work RVU of 0.18 was assigned by CMS in the 2013 Final Rule via the direct crosswalk to CPT code 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional,* given the similarities in work related to screening. In April 2022, the Relativity Assessment Workgroup identified this service with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020. In September 2022, the RUC recommended that this service be surveyed for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.

The specialty societies surveyed depression screening code G0444 for the April 2023 RUC meeting but did not obtain the required number of survey responses. The RUC recommended the specialty societies work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify physicians and other qualified healthcare professionals who predominantly perform G0444 and match them with societies to survey those individuals. The specialty societies were also encouraged to expand their random survey sample to other sections of their membership that are more likely to perform this service. As a result, the specialty societies continued to collect survey responses for the September 2023 RUC meeting and worked with the Research Subcommittee to identify a targeted survey sample in addition to an expanded random sample. The specialties were successful in exceeding the minimum number of survey responses for the code for the September 2023 RUC meeting.

G0444 *Annual depression screening, 5 to 15 minutes*
The RUC reviewed the survey results from 94 physicians and recommends a work RVU of 0.18 based on the current work RVU that is supported by other similar services in the MFS. The RUC recommends 5 minutes intra-service and total time. As G0444 is typically performed with an E/M service, the RUC removed all pre- and post-service time to ensure that the time and work valuation is separate and distinct from same-day E/M services.

For this screening, the physician or qualified healthcare professional (QHP) reviews the responses to the completed screening instrument with the patient. The physician or QHP validates responses to the screening instrument and probes any issues with the patient as needed. The physician or QHP assesses the responses to determine if counseling, a referral, or treatment is needed. The physician or QHP documents clarification of the patient's response and referral or treatment plan.

To support the recommended work RVU, the RUC compared the surveyed code to second key reference code 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* (work RVU = 0.18 and 7 minutes total time) and top key reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70 and 16 minutes total time). The key reference services appropriately bracket the surveyed code. The second key reference service, 99211, has an identical work RVU, although slightly lower times and the first key reference service, 99212, has overall higher times and an appropriately higher work RVU.

For additional support, the RUC compared the surveyed code to MPC code 96374 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug* (work RVU = 0.18, 5 minutes intra-service, 9 minutes total time) and noted that the work value recommendation for the surveyed code is identical to the comparator code given the identical intra-service time and similar total time. **The RUC recommends a work RVU of 0.18 for code G0444.**

Practice Expense
The Practice (PE) Subcommittee reviewed and affirmed the direct practice inputs from April 2023 without modification. At the April 2023 meeting, the PE Subcommittee reviewed the direct practice expense inputs and made several modifications. The clinical staff time was reduced for CA021 *Perform procedure/service---NOT directly related to physician work* to five minutes as the typical time for the clinical staff to administer the screening tool. Additionally, supply item SK062 *patient education booklet* was eliminated in favor of SK057 *paper, laser printing (each sheet)* in the amount of 10 sheets. Lastly, the equipment time for EF023 *table, exam* was reduced from 15 minutes to 13 minutes which is equal to 5 minutes of clinical staff time plus 8 minutes of physician/QHP time and reflects the median from survey. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

<u>Behavioral Counseling & Therapy (Tab 17)</u>
Charles Hamori, MD (ACP), Amber Isley, MD (AAFP), Len Lichtenfeld, MD (ACP)

In April 2022, the Relativity Assessment Workgroup identified services with Medicare utilization of 10,000 or more that have increased by at least 100% from 2015 through 2020, including codes G0445-G0447. In September 2022, the RUC recommended that these services be surveyed for April 2023 after CMS publishes revised code descriptions in the Final Rule for 2023.

The specialty societies surveyed behavioral counseling codes G0445-G0447 for the April 2023 RUC meeting but did not obtain the required number of survey responses. The RUC recommended that the specialty societies work with the Research Subcommittee to develop a targeted survey, using the Medicare Claims database to identify physicians and other qualified healthcare professionals who predominantly perform G0445-G0447 and match them with societies to survey those individuals. The specialty societies were also encouraged to expand their random survey sample to other sections of their membership that are more likely to perform these services. As a result, the specialty societies continued to collect survey responses for the September 2023 RUC meeting and worked with the Research Subcommittee to identify a targeted survey sample in addition to an expanded random sample. The specialty societies were again unable to achieve the required minimum number of survey responses for any of the codes in this family for the September 2023 RUC meeting.

G0445 ***High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes***
The RUC reviewed the survey results from 22 family medicine and internal medicine physicians and noted that the required minimum number of survey responses, 30, was not achieved. Also, the RUC noted that G0445 is a CMS-created time-based code with 30 minutes of time assigned in the code's long descriptor. The RUC acknowledged that this low-volume service is assigned the same value currently as G0446 and G0447 though twice the amount of physician time. **Given the constraints of an insufficient number of survey responses and this being a CMS-created time-based code, the RUC determined it would be most appropriate to maintain the current times and values at this time.** The RUC would also flag this service for review in 3 years and for the service to not be used as a comparison code.

For G0445, CMS covers up to two individual face-to-face counseling sessions annually for Medicare beneficiaries for high intensity behavioral counseling to prevent sexually transmitted infections (STIs), for all sexually active adolescents, and for adults at increased risk for STIs if provided by a Medicare eligible primary care provider in a primary care setting.

To justify maintaining a work value of 0.45, the RUC compared the surveyed code to top key reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU= 0.70, 16 minutes of total time) and noted that this reference code supports maintaining the current value for the surveyed code and would not overvalue the service. **The RUC recommends a work RVU of 0.45 for CPT code G0445.**

G0446 ***Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes***
The RUC reviewed the survey results from 26 family medicine and internal medicine physicians and noted that the required minimum number of survey responses was not achieved (at least 50 survey responses for a service with Medicare volume between 100,000 and 1 million claims). The RUC recommends 15 minutes intra-service and total time. **Given the constraints of an insufficient number of survey responses and this being a CMS-created time-based code, the RUC determined it would be most appropriate to maintain the current times and values at this time.** The RUC would also flag this service for review in 3 years and for the service to not be used as a comparison code.

For G0446, CMS covers one face-to-face cardiovascular disease risk reduction visit per year for Medicare beneficiaries whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

To justify maintaining a work value of 0.45, the RUC compared the survey code to top key reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU= 0.70, 16 minutes of total time) and noted that this reference code supports that maintaining the current value for the survey code would not overvalue the service. The RUC also compared the surveyed code to MPC code 99407 *Smoking and tobacco use*

cessation counseling visit; intensive, greater than 10 minutes (work RVU=0.50, intra-service and total time of 15 minutes).

As G0446 is typically performed with an E/M service, the RUC ensured that maintaining the current value would assign a valuation that did not include duplicative work from a same-day E/M service. **The RUC recommends a work RVU of 0.45 for CPT code G0446.**

G0447 ***Face-to-face behavioral counseling for obesity, 15 minutes***
The RUC reviewed the survey results from 35 family medicine and internal medicine physicians and noted that the required minimum number of survey responses was not achieved (at least 50 survey responses for a service with Medicare volume between 100,000 and 1 million claims). The RUC recommends 15 minutes of intra-service and total time. **Given the constraints of an insufficient number of survey responses and this being a CMS-created time-based code, the RUC determined it would be most appropriate to maintain the current times and values at this time.** The RUC would also flag this service for review in 3 years and for the service to not be used as a comparison code.

For G0447 and Medicare beneficiaries with obesity, CMS covers one face-to-face visit every week for the first month, one face-to-face visit every other week for months 2-6 and one face-to-face visit every month for months 7-12 (if the beneficiary meets a 3kg weight loss requirement during the first six months). The G0447 visits would also only be covered when furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting.

To justify maintaining a work value of 0.45, the RUC compared the surveyed code to top key reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU= 0.70, 16 minutes of total time) and noted that this reference code supports that maintaining the current value for the surveyed code would not overvalue the service. The RUC also compared the surveyed code to MPC code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU=0.50, intra-service and total time of 15 minutes).

As G0447 is typically performed with an E/M service, the RUC ensured that maintaining the current value would assign a valuation that did not include duplicative work from a same-day E/M service. **The RUC recommends a work RVU of 0.45 for CPT code G0447.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed and affirmed the direct practice inputs from April 2023 without modification. At the April 2023 meeting, the PE Subcommittee reviewed the proposed direct practice expense inputs and made a couple modifications: SK062 *patient education booklet* was eliminated in favor of SK057 *paper, laser printing (each sheet)* in the amount of 10 sheets, and the equipment minutes were modified to equal the sum of clinical staff time plus the physician/QHP time as reflected by the survey median. The PE Subcommittee agreed with the specialties' modification of the clinical staff time to move two minutes from CA021 *Perform procedure/service---NOT directly related to physician work time* to CA035 *Review home care instructions, coordinate visits/prescriptions.* This more accurately reflects the clinical work involved in arranging follow-up and/or referrals with clinical and community resources and providing educational materials. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

Relativity Assessment Workgroup Review
The RUC recommends that the Relativity Assessment Workgroup review CPT codes G0445, G0446 and G0447 in three years as these services did not achieve the required minimum number of survey responses. Also, as G0445 and G0446 did not achieve 30 responses, specialty societies will be asked in three years to submit an action plan indicating whether these services should be resurveyed, referred to CPT to create a Category I code or referred to CMS for deletion or revision.

RUC Database Flag
CMS HCPCS codes G0445, G0446 and G0447 did not achieve the required number of survey responses and therefore would not be appropriate comparators for other services. The RUC notes that they will be flagged as "**Do not use to validate for physician work."**

XI. Relative Value Recommendations for CPT 2023

<u>COVID-19 Immunization Administration – Revised Code Set (Tab 18)</u>
Eilean Attwood, MD (ACOG), Suzanne Berman, MD (AAP), Jon Hathaway, MD (ACOG), Steven Krug, MD (AAP)

On August 14, 2023, new CPT codes were created to consolidate over 50 previously implemented codes and streamline the reporting of immunizations for the novel coronavirus (SARS-CoV-2, also known as COVID-19). The CPT Editorial Panel approved the addition of new product codes 91318-91322 to identify monovalent vaccine product for immunization against COVID-19 (Pfizer, Moderna); retained existing Novavax Product Code 91304 for currently authorized vaccine product available for use in the U.S. and the updated (XBB.1.5) vaccine; deleted and/or revised all other existing COVID codes (product and administration with associated guidelines and parenthetical note deletions/revisions); and added a single administration code (90480) for administration of new (i.e., 91318-91322) and existing (i.e., 91304) COVID-19 vaccine products.

All existing CPT codes that describe COVID-19 vaccine products and associated administration codes that end in "A" for products that are no longer covered under an existing Emergency Use Authorization (EUA) or Biologics License Application (BLA) from the US Food and Drug Administration (FDA) will be deleted effective November 1, 2023.

In August 2023, the specialty societies conducted an expedited survey to value the consolidated single COVID-19 immunization administration code, CPT code 90480. The RUC reviewed the specialty societies' recommendation at the September 2023 RUC meeting.

90480 ***Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose***
The RUC reviewed the survey results from 171 pediatricians and obstetricians/gynecologists and determined that the survey median work RVU of 0.25 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of intra-service/total time. The RUC noted that this service is typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time is not duplicative from that which is included in the E/M visit.

The RUC compared the surveyed code with the top key reference service 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (work RVU = 0.24 and 7 minutes intra-service/total time). The RUC noted that 70% of the respondents who chose CPT code 90460 as the key reference service indicated the surveyed code

is overall slightly more intense and complex to perform. This is supported by the additional complexity of the intra-service work as compared to 90460 based on the need to address ongoing vaccine hesitancy associated with COVID-19. Analysis from the CDC's State of Vaccine Confidence Insights Report, KFF COVID-19 Vaccine Monitor, American Academy of Family Physicians, American College Health Association, American Academy of Pediatrics, and Journal of Community have shown that the COVID-19 pandemic has had a profound effect on vaccine confidence, with a significant overall increase in vaccine hesitancy. Notably, COVID-19 vaccines have experienced the highest level of hesitancy compared to other vaccines. Therefore, the RUC determined that the physician or QHP work is slightly more for code 90480 compared to 90460.

The RUC compared the surveyed code to the second top key reference service 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17 and 7 minutes intra-service/total time). The RUC noted that while both services require the same amount of time, offering CPT code 90471 (such as for seasonal influenza), which entails less physician work and is less intense/complex. CPT code 90741 is valued appropriately lower, as there is slightly less patient education and discussion about vaccination hesitancy when compared to the COVID related patient education and vaccine protection that is required for CPT code 90480.

For additional support, the RUC referenced MPC codes 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU = 0.24 and 7 minutes intra-service/total time) and 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32, 7 minutes intra-service time and 9 minutes total time), which places the surveyed code in the proper rank order based on the intensity, complexity, and time required to perform this service. **The RUC recommends a work RVU of 0.25 for CPT code 90480.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. The specialty societies recommended identical inputs as recently reviewed and approved for immunization administration code 90460. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology/New Services
The RUC recommends that CPT code 90480 be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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

RSV Monoclonal Antibody Administration (Tab 19)
Suzanne Berman, MD (AAP), Steven Krug, MD (AAP)

At the September 21-23, 2023, CPT meeting, the CPT Editorial Panel created two codes to report passive administration of respiratory syncytial virus, monoclonal antibody, seasonal dose, with and without counseling. CPT codes 96380 and 96381 were reviewed the following week at the September 28-30, 2023, RUC meeting. These two administration codes were created to be reported with Nirsevimab product codes to protect against severe disease caused by RSV, which is common

throughout the fall and winter season, highly contagious and sometimes deadly for infants. CPT codes 96380 and 96381 will be effective October 6, 2023, for immediate use.

96380 ***Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional***
The RUC recommends a work RVU of 0.24 based on a direct crosswalk to CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (work RVU = 0.24 and 7 minutes intra-service and total time), which maintains relativity within the Medicare Physician Payment Schedule. The RUC recommends 7 minutes intra-service and total time. There is no pre-service or post-service time as this service is typically reported with an Evaluation and Management (E/M) office visit.

For additional support, the RUC compared code 96380 to MPC code 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU = 0.24 and 7 minutes intra-service time and total time), code 88311 *Decalcification procedure (List separately in addition to code for surgical pathology examination*) (work RVU = 0.24, 5 minutes intra-service time and 7 minutes total time), 77073 *Bone length studies (orthoroentgenogram, scanogram)* (work RVU = 0.26, 5 minutes intra-service time and 7 minutes total time) and 92202 *Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral* (work RVU = 0.26, 5 minutes intra-service time and 7 minutes total time). The RUC determined that an interim work value of 0.24 appropriately places 96380 relative to other services based on time, work, intensity and complexity. **Therefore, the RUC recommends an interim work RVU of 0.24 for code 96380 and the specialty societies will survey this service for the April 2024 RUC meeting after more widespread use has occurred.**

96381 ***Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection***
The RUC recommends a work RVU of 0.17 based on a direct crosswalk to CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17, 7 minutes intra-service and total time), which maintains relativity within Medicare Physician Payment Schedule. The RUC recommends 7 minutes intra-service and total time. There is no pre-service or post-service time as this service is typically reported with an Evaluation and Management (E/M) office visit.

For additional support, the RUC compared code 96381 to MPC code 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* (work RVU = 0.18 and 5 minutes intra-service time and 7 minutes total time) and code 90970 *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older* (work RVU = 0.18, 3.2 minutes intra-service and total time). The RUC determined that an interim work value of 0.17 appropriately places 96381 relative to other services based on time, work, intensity and complexity. **Therefore, the RUC recommends a work RVU of 0.17 for code 96381 and the specialty societies will survey this service for the April 2024 RUC meeting after more widespread use has occurred.**

Practice Expense
The Practice Expense Subcommittee reviewed and accepted the practice expense inputs as submitted by the specialty society. The direct practice expense inputs are a direct crosswalk to 90460 and

90471, respectively. One additional minute of clinical staff time was added to complete vaccine pre-check eligibility process (see attachment Nirsevimab Visual Guide). **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

XII. Research Subcommittee (Tab 20)

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

The Research Subcommittee did not have a separate general policy meeting which coincided with the September 2023 RUC meeting. The Subcommittee had last met on May 22nd, 2023, to review specialty society requests pertaining to RUC surveys for the September 2023 meeting and to review one general policy item. On the May 22nd call, the Research Subcommittee reviewed and approved proposed vignettes, custom survey templates, a targeted survey sample methodology request and discussed RUC crosswalks and reference code guidelines.

RUC Crosswalk and Reference Codes General Guidelines
During the January 2023 RUC New Business discussion, a RUC member requested general guidelines/guidance for the use of crosswalk codes to support valuation recommendations. This item was referred to the Research Subcommittee for consideration. At the April 2023 RUC meeting, the Subcommittee discussed whether it would be appropriate to create guidance language with absolute criteria for the RUC panel itself. The Subcommittee agreed that that would not be warranted, since the current process is currently working as intended. In lieu of guidelines for the RUC itself, AMA RUC staff drafted text for inclusion in the "Instructions for Developing Work Value Recommendations" document for the Subcommittee's consideration. This document, which is a reference for specialty society advisors and staff, already has a section on alternate ways to develop work RVU recommendations, though does not specifically cover crosswalk codes. The Subcommittee agreed that inclusion of language like this, in general, would be warranted, though suggested for the text to undergo additional wordsmithing.

At the RUC's New Business discussion in April 2023, a RUC member requested standard parameters for RUC database searches and guidelines for crosswalks. Other RUC members present supported this request. The request was referred to the Research Subcommittee for discussion. As the ongoing item regarding crosswalks and this new one pertaining to reference codes overlap; their discussion was combined and discussed on the May 22nd, 2023, Research Subcommittee call.

The Chair of the Research Subcommittee, AMA RUC Staff and another Subcommittee member who submitted suggestions collaborated on the below revised text for the Subcommittee's consideration. The Research Subcommittee concurred that the updated text was appropriate as proposed (underlined below).

The Research Subcommittee approved the new language as follows for the "Instructions for Developing Work RVU Recommendations" document:

> **Alternative Ways to Develop Work Relative Value Recommendations:**
> The RUC requires that a survey be conducted for each CPT code presented to the RUC. The survey data is the primary source of information to value physician work for codes presented to the RUC. However, the specialty and/or the RUC may find that the survey results are either flawed or need additional support and may consider alternative ways to develop work relative values. The Specialty RVS committee may wish to consider the following alternative ways of valuing the codes other than use of the survey results, either as a means of strengthening the rationales for its recommendations or as an alternative basis for its

recommendations. If either of these alternates is used instead of or in support of the survey results, include a justification on the Summary of Recommendation form.

- Expert Panel Methodology: The survey remains the primary source of information to value physician work for codes submitted to the RUC. Expert panel methodology may be submitted if a specialty society determines that the survey may be flawed or needs to be supplemented. A specialty society that chooses to use an expert panel as its primary source of developing a work relative value recommendation must present the survey data and their rationale for using the expert panel.

  The expert panel methodology may use comparison codes to determine an appropriate work value recommendation. A "crosswalk" comparison code is a RUC-reviewed code with the same amount of physician work as the survey code, hence the work RVU for the survey code will match that of the crosswalk code. In addition, the survey code and the crosswalk code should have the same global period. Whenever possible, the crosswalk code should have been reviewed by the RUC recently, have a similar amount of intra-service and total time, have clinical similarities to the survey code, and not be flagged in the database as problematic for comparison. In addition, "reference" comparison codes should be used to support the expert panel's recommendations. A reference code does not need to have the same work RVU as the code under review; however, whenever possible, should share the other attributes of the "crosswalk" codes. A search of the RUC Database will assist specialties and RUC reviewers in finding crosswalk and reference codes that meet these parameters.

The RUC approved the Research Subcommittee Report.

XIII. Practice Expense Subcommittee (Tab 21)

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

The PE Subcommittee formed a PE Packs Workgroup at the April 2023 meeting to review the content of the supply packs to assess if they are still typical and revise as necessary. This was the result of discrepancies found with the packs pricing at the January 2023 RUC meeting. Doctor Manaker reminded the RUC that the recommendations of the PE Packs Workgroup report were approved by the full RUC in July so that its recommendations could be included in the RUC comment letter on the 2024 Medicare Physician Payment Schedule Proposed Rule. The RUC shared its deconstructed packs spreadsheet and recommendations with CMS in the RUC comment letter, dated Augst 14, 2023. **The RUC requests that CMS immediately initiate correction of the packs pricing such that the sum of the individual components match the price of the corresponding pack.**

The PE Subcommittee also continued its discussion of post-operative patient communications, specifically as it relates to phone calls outside of the 090-day global standard. **The PE Subcommittee determined, and the RUC agreed, that there should be no change to the existing benchmark standard for phone calls:**

- All phone calls, standardized to 3 minutes. No phone calls are allowed in the post-operative period for 010 and 90 day global codes.

CPT codes with their respective inputs should continue to be presented on a case-by-case basis (as occurred with CPT codes 30117 and 30118 in January 2023).

Further, the PE Subcommittee acknowledged that 010 and 090-day global codes are increasingly being performed in an outpatient setting. Therefore, some of the phone calls inherent with an overnight stay may instead be omitted with the ½ day discharge visit. The Subcommittee discussed the existing benchmark standard for Discharge Day Management:

- Discharge day management
  If the claims data indicate site-of-service is:
  less than 50% inpatient – 6 minutes (0.5 of 99238)
  greater than 50% inpatient – 12 minutes (99238); 15 minutes (99239)
  more than 50% non-facility (e.g., office) – 0 minutes

The PE Subcommittee determined, and the RUC agreed, that requests for phone calls will require (a) specific rationale from the specialties for additional calls outside of the discharge day management standard and the phone calls associated with postoperative office visits; or (b) a survey question to provide data demonstrating that the additional calls are performed outside these two standards.

The RUC approved the Practice Expense Subcommittee Report.

XIV. Relativity Assessment Workgroup (Tab 22)

Matthew Grierson, MD, Chair of the Relativity Assessment Workgroup (RAW), provided the RUC with a summary of the Workgroup's report.

Doctor Grierson indicated that the Relativity Assessment Workgroup (RAW) had an active meeting reviewing 28 action plans for codes and code families identified by various screens. The screens were site of service anomalies, high volume growth, CMS/Other source codes, codes surveyed by one specialty and now performed by a different specialty, Category III codes with high volume, CPT Assistant analysis, work neutrality and a general flag for re-review by the RUC. The Workgroup recommended that two code families be surveyed, eight code families be referred to CPT for restructuring, clarification or bundling and three code families be referred to CPT Assistant for clarification.

The Workgroup discussed all of the screens related to practice expense that the RAW has considered. There were three such screens related to practice expense: Services with Stand-Alone PE Procedure Time, High Cost Supplies and PE Units Screen. The Workgroup recommended lowering the Medicare allowed charges threshold from $100,000 to $50,000 for the Services with Stand-Alone PE Procedure Time screen, including direct equipment inputs that total in direct expense to the individual code to $100 or more, and have PE procedure times greater than five minutes. **The Relativity Assessment Workgroup will review the results from the Services with Stand-Alone PE Procedure Time screen at the lower threshold of $50,000 Medicare allowed charges for the January 2024 Workgroup meeting.** The Workgroup also requested any additional input from the Practice Expense Subcommittee regarding conducting any additional PE screens to identify potentially misvalued services.

The RUC approved the Relativity Assessment Workgroup Report.

XV. New Business (Tab 23)

- A RUC Member expressed concern regarding when the dominant specialties for a tab make the active decision to not survey an upcoming code family, despite AMA staff and RUC member efforts. The member emphasized that it is imperative that the RUC continue to ensure that the surveys conducted are robust and representative of the physician work and further, meet the required survey thresholds. Another RUC member responded and offered that there are many practicalities to consider when approaching the survey process and those should be considered when discussing a possible solution.

- A RUC Member expressed concern for Category III codes that move to Category I codes and the related evidence that the code(s) have widespread utilization, however, when the code(s) enter the survey process it can be difficult to achieve the survey threshold. The CPT Representative offered that the CPT Editorial Panel has discussed the definition of widespread use and is aware that an adequate number of physicians who perform the service are needed to conduct a RUC survey.

- A RUC Member inquired about the possibility of acquiring Medicare Advantage data for the RUC database given that the beneficiary population may add value to the RUC database. AMA staff offered that the AMA has been working with CMS to obtain other data sets such as the Medicaid data for quite some time and are hopeful that these data will be made available. The AMA will continue to explore the availability of consistent and representative claims databases.

The RUC adjourned at 5:13 PM CT on Saturday, September 30, 2023.

AMA/Specialty Society RVS Update Committee **Tab 12**
Research Subcommittee Report
Thursday, September 26, 2024

Members Present: Margie Andreae, MD (Chair), Jeffrey Paul Edelstein, MD (Vice Chair), , DO, Michael Doll, PA-C, Leisha Eiten, AuD, CCC-A, John Heiner, MD, Omar Hussain, DO, Kevin Kerber, MD, M. Douglas Leahy, MD, Swati Mehrotra, MD, Anne Miller, MD, Lauren Nicola, MD, Mark Villa, MD, David Yankura, MD, Robert Zipper, MD, Robert Zwolak, MD

I. Minutes, May 29th Research Subcommittee Specialty Requests Meeting Report Review

The Research Subcommittee report from the May 29th conference call included in Tab 12 agenda materials was approved without modification.

II. Discussion – RUC Use of Crosswalks

At the April 2024 RUC meeting, a RUC member inquired about the number of times a crosswalk code did not have the same global period as the surveyed code (as that was the case for one code at the April 2024 meeting). The RUC referred this issue to the Research Subcommittee for review at the September 2024 meeting.

In September 2024, AMA staff provided the Subcommittee with an analysis of the RUC recommendations for 495 codes from the CPT 2021-2025 RUC cycles which also underwent a RUC survey. 82 (17%) of these recommendations were based on a crosswalk. When the RUC recommendation was based on a crosswalk code, the RUC always recommended an identical work RVU. In addition, both services had identical global period assignments 100% of the time. For a significant number of codes, the RUC recommended time was within 10% of the time for the crosswalk code (87% intra-time and 51% total-time). Every crosswalk code selected had been reviewed by the RUC (100%).

Crosswalk usage data (CPT 2021 – CPT 2025):

Number of RUC Recommendations w/ Crosswalk*	**82**
Identical Work RVUs	**100%**
Identical Global Periods	**100%**
Identical Intra-service Times	**71%**
Intra-Time within 10%	**87%**
Intra-Time within 20%	**91%**
Identical Total Time	**24%**
Total Time within 10%	**51%**
Total Time within 20%	**68%**
IWPUTs within 10%	**70%**
IWPUTs within 20%	**82%**
Crosswalk Code reviewed by RUC	**100%**
Crosswalk Code reviewed by RUC in previous 10 years	**70%**
Medicare Util >1,000	**85%**
MPC List	**15%**
Top 3 Specialties for Crosswalk Code is also a surveying society for the survey code	**45%**

**Only includes codes under review which were surveyed for physician work; excludes same-cycle interim recommendations.*

The Chair noted that at the September 2023 RUC meeting, the RUC approved language regarding crosswalks including that they should have the same global period, be recently reviewed, have similar intra-service time and total time, be clinically similar to the surveyed code, and not be flagged as "Do Not Use to Validate Physician Work" in the RUC database. However, these guidelines are included in the instructions for developing work RVU recommendations document which is for specialty societies developing recommendations and do not limit the RUC or facilitation committees specifically as they review RVU recommendations for a code or code family.

After review of the analysis prepared by AMA staff, the Subcommittee concluded that the RUC has an excellent track record over the past five years of selecting crosswalks that are consistent with the guidelines provided to the specialty societies and no defined requirements for the RUC are indicated. The Subcommittee noted that there were no instances of differing globals for the 5 years prior to the April 2024 meeting. **The Research Subcommittee agreed that no changes were warranted for the RUC's crosswalk methodology.**

III. RUC Intensity and Complexity Survey Questions

During the April 2024 RUC New Business discussion, a RUC member inquired about the intensity/complexity survey questions and the use of "identical" as the midpoint of the five-point comparison scale included in the standard RUC survey templates or if the midpoint should instead state "similar" intensity/complexity compared to the key reference services. The inquiry was based on a concern that survey respondents may be reluctant to select the term "identical" as this implies an exactness. The RUC referred this item for consideration by the Research Subcommittee at the September 2024 meeting.

In September 2024, the Chair noted that the Likert scale is most often five points to allow enough options without overwhelming the respondent. The scale can be used to measure magnitude from low to high (1-5) or measure relativity with two degrees of separation from neutral (strongly agree, somewhat agree, neutral, somewhat disagree, strongly disagree). The RUC intensity survey question measures intensity relative to the KRS using two degrees of separation with neutral where neutral is "identical." Other potential option to express neutral would be to use the terms "similar", "no difference" or "same."

Several Subcommittee members expressed support for switching away from "identical", which many concurred was too exact. Many members expressed support for the term "same". One member suggested "nearly the same". Also, the Subcommittee discussed changing the intensity/complexity question to remove the word "directly" from the following sentence: "Using your expertise, consider how each survey code compares directly to the corresponding reference code." Several Subcommittee members expressed support for this change as well.

The Research Subcommittee determined that the members and staff needed to consider the change, seeking out additional information about the impact of the terms "same" and "identical" in survey research. The Subcommittee did not make a final decision on these changes and will continue this discussion at a future meeting.

IV. Proposed Custom RUC Survey for Lower Extremity Revascularization (LER) Services

The American College of Cardiology (ACC)
The American College of Radiology (ACR)
The American College of Surgeons (ACS)

The Outpatient Endovascular and Interventional Society (OEIS)
The Society for Cardiovascular Angiography and Interventions (SCAI)
The Society for Vascular Surgery (SVS)
The Society of Interventional Radiology (SIR)

At the September 2024 CPT Editorial Panel meeting, the Panel created 46 new CPT code to describe Lower Extremity Revascularization (LER) services and deleted the 16 existing lower extremity revascularization codes. The surveying societies submitted a proposal for surveying these codes for the January 2025 meeting using a custom survey instrument.

Prior to the meeting, the surveying specialty societies submitted a proposal to conduct a standard RUC survey of 10 anchor codes for the family and then conduct an abbreviated survey for the other 46 codes in the same template, with the abbreviated-surveys split into three separate groupings: (1) Tibial – Peroneal, (2) Femoral – Popliteal and (3) Iliac + Inframalleolar. Each physician in the sample would receive a standard RUC survey for the 10 anchor codes and one abbreviated survey. The specialty societies will break up their samples to evenly distribute the abbreviated surveys. The presenters noted that the intent of their proposal is to avoid survey fatigue and to maximize the number of survey responses for each code.

The presenters noted the abbreviated portion of the survey for the remainder of the codes would present the CPT code, CPT descriptor, and Vignette. The respondent would be asked to affirm the vignette, provide Intra Time, Overall Complexity, Estimated Work RVU, and 12 Month Experience without selecting a reference service code. The abbreviated portion of the surveys would also include the survey respondent's answers from the anchor codes populated into the abbreviated survey table to allow comparison. All 000 pre/post time cells in the abbreviated portion of the survey would be pre-populated (editable) based on pre- and post- packages selected for the anchoring codes. For the single intensity/complexity question in the abbreviated portion of the survey, an anchor survey code from the same territory would be provided for comparison/reference.

Subcommittee members overall were supportive of the request for a combined full and abbreviated survey. Several Subcommittee members expressed concern with the initial proposal to divide respondents into three groupings with a preference for two groupings, and also expressed concerns with the group of anchor survey codes not having an angioplasty only service. Subcommittee members requested for the societies to consider switching the abbreviated survey groupings to two groups instead of three. Also, the Subcommittee requested for the societies to reconsider the representation of anchor codes that would receive a full RUC survey. The Chair suggested the societies consider adding a question on the survey to assess the typical number of blockages/stenoses typical for the femoral/ popliteal stent and/or atherectomy/stent codes.

In order to provide additional time to the surveying societies, the Research Subcommittee reconvened the next morning. The societies provided an updated proposal with 11 anchor survey codes which represented every territory in the family, straightforward procedures, complex procedures, angioplasty only procedures, stent placement procedures, atherectomy procedures and add-on procedures. Also, the societies provided two groupings of abbreviated survey codes instead of three. Finally, the societies provided a list of which comparator codes would be used for the intensity/complexity question for each abbreviated survey code (included in the September 2024 handouts at the meeting folder). **The Research Subcommittee approved the custom survey instrument and methodology as follows:**

Research-Approved Core Survey Codes (Standard RUC Survey):

37X01 **37X02**	Iliac, angioplasty, init, SF + Iliac, angioplasty, addl, SF
37X03	Iliac, angioplasty, init, CX
37X09	+ Iliac IVL
37X14	Fem-Pop, angioplasty stent, init, SF
37X15	+ Fem-Pop, angioplasty stent, addl, SF
37X16	Fem-Pop, angioplasty ather, init, CX
37X35	Tibial, angioplasty ather, init, SF
37X36	+ Tibial, angioplasty ather, addl, SF
37X37	Tibial, angioplasty ather, init, CX
37X43	Inframalleolar, angioplasty, init, SF

Research-Approved Abbreviated Survey Groupings:
Abbreviated Survey Group 1:

37X04	+ Iliac, angioplasty, addl, CX
37X05	Iliac, angioplasty stent, init, SF
37X06	+ Iliac, angioplasty stent, addl, SF
37X07	Iliac, angioplasty stent, init, CX
37X08	+ Iliac, angioplasty stent, addl, CX
37X10	Fem-pop, angioplasty, init, SF
37X11	+ Fem-pop, angioplasty, addl, SF
37X12	Fem-pop, angioplasty, init, CX
37X13	+ Fem-pop, angioplasty, addl, CX
37X17	+ Fem-pop, angioplasty stent, addl, CX
37X18	Fem-pop, angioplasty ather, init, SF
37X19	+ Fem-pop, angioplasty ather, addl, SF
37X20	Fem-pop, angioplasty ather, init, CX
37X21	+ Fem-pop, angioplasty ather, addl, CX
37X22	Fem-pop, angioplasty ather stent, init, SF
37X23	+ Fem-pop, angioplasty ather stent, addl, SF
37X24	Fem-pop, angioplasty ather stent, init, CX
37X25	+ Fem-pop, angioplasty ather stent, addl, CX
37X26	+ Fem-pop IVL

Abbreviated Survey Group 2:

37X27	Tibial, angioplasty, init, SF

37X28	+ Tibial, angioplasty, addl, SF
37X29	Tibial, angioplasty, init, CX
37X30	+ Tibial, angioplasty, addl, CX
37X31	Tibial, angioplasty stent, init, SF
37X32	+ Tibial, angioplasty stent, addl, SF
37X33	Tibial, angioplasty stent, init, CX
37X34	+ Tibial, angioplasty stent, addl, CX
37X38	+ Tibial, angioplasty ather, addl, CX
37X39	Tibial, angioplasty ather stent, init, SF
37X40	+ Tibial, angioplasty ather stent, addl, SF
37X41	Tibial, angioplasty ather stent, init, CX
37X42	+ Tibial, angioplasty ather stent, addl, CX
37X44	+ Inframalleolar, angioplasty, addl, SF
37X45	Inframalleolar, angioplasty, init, CX
37X46	+ Inframalleolar, angioplasty, addl, CX

Research-Approved Questions for Abbreviated Portio of the Survey

New Codes	**CPT Codes** **CPT Descriptor**	
Typical Patients	**Is your typical patient for this procedure similar to the typical patient described?**	Yes or No
	If no, please describe your typical patient	
Physician Time	**How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? [Pre and Post times piped from package times]**	Pre Eval
		Pre Pos
		Pre SDW
		INTRA
		Imm Pos
		Total Time
Intensity/Complexity	**Compare OVERALL intensity/complexity of all physician work you perform for the new codes relative to [Piped Comparator Code]**	
Physician Work RVUs	**Based on your review of all previous questions, please provide your estimated work RVU (to the 2nd decimal place) for the new codes.**	

Experience	How many times have you personally performed these procedures in the past 12 months?

AMA/Specialty Society RVS Update Committee **Tab 13**
Practice Expense Subcommittee
September 26, 2024

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

I. High-Cost Supplies

At the January 2024 meeting, the Practice Expense (PE) Subcommittee expressed its continued concern with the issue of high-cost supplies and the need to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. At the same meeting, a RUC member suggested that codes with high-cost disposable supplies be flagged for PE re-review.

In April 2024, the PE Subcommittee continued to examine this issue, noting that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting. Moreover, the Subcommittee noted the significant scaling factors that are applied for budget neutrality as part of the PE methodology, which may result in payments that are lower than the cost to provide a service. At the same meeting, the Relativity Assessment Workgroup (RAW) discussed this issue to determine if a useful screen should be developed to identify any potentially misvalued services.

For the September 2024 meeting, the discussion and analysis of the high-cost supplies issue was referred to the RAW meeting (Tab 14). AMA staff provided data which show:

- There are 69 services in which the total practice expense payment does not cover the total direct supply expense for the code.
- There are 53 of these 69 services in which a high cost disposable supply is over $500.
- For 6 of these 53 services, the practice expense payment does not even cover the cost of a single high-cost supply utilized in the provision of the service.

The RAW examined the data and considered whether codes with high-cost disposable supplies should be flagged for PE re-review through development of a High-Cost Disposable Supplies Screen. The Workgroup indicated that it would be part of existing precedent to identify services for PE review only. The Workgroup also discussed whether new invoices should be required for supplies over $500 for the RUC to submit to CMS. Staff emphasized that for nearly 20 years, **the RUC has called on CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The RAW requested formation of a joint CPT and RUC workgroup to address the issue of high-cost disposable supplies.**

II. Radiology-specific Clinical Activities

At the April 2024 RUC meeting, the PE Subcommittee considered the use of Clinical Activity (CA) code CA014 *Confirm order, protocol exam*. The guidelines for this clinical activity specify "For use in imaging services only. 1 minute standard." It was noted that CA014 has been repeatedly requested for non-imaging procedures despite the instructions which state that the task is only for imaging. Further, protocoling exams has a very specific meaning in CT and MRI that describes the work of choosing which

imaging sequences or contrast phases to perform. The task of verifying the correct patient and procedure or medication happens in nearly every procedure (aka the "time out") or medication administration, and is not intended to receive additional time in a relative system. After considering a database search that showed over 20 of the 66 codes with CA014 greater than 0 minutes are non-imaging, **the PE Subcommittee agreed that the CA014 minutes could be allocated in the non-radiology codes.** The Subcommittee discussed how the work being described in the injection and immunization codes, for example, is broadly performed across the code set and is not strictly protocoling.

For the September 2024 meeting, the PE Subcommittee discussed examples for CA014 to include in the *Practice Expense Direct Input Benchmarks* document. For example, CA010 *Obtain vital signs* specifies different levels and vital signs for consistency:

5. The obtaining of vital signs, standardized into 3 levels of service with the following times: Level 0 (no vital signs taken) = 0 minutes, Level 1 (1-3 vitals) = 3 minutes, Level 2 (4-6 vitals) = 5 minutes. (Approved April 2000).

The PE Subcommittee determined updates to the Benchmarks for CA014 to read as follows:

7. **Confirm order, protocol exam, standardized to 1 minute., e.g., selecting which imaging sequences or contrast phases to perform in CT and MRI. 0 minutes for verifying the correct patient and procedure/ medication (aka the "time out").**

The PE Subcommittee further determined that for the six codes below which state "For use in imaging services," the statement should be removed such that the specialties can justify the 1 or 2 minute standard for each procedure as needed.

CA006	Confirm availability of prior images/studies	General Activity	For use in imaging services. 2 minute standard.
CA007	Review patient clinical extant information and questionnaire	General Activity	For use in imaging services. 1 minute standard.
CA014	Confirm order, protocol exam	General Activity	For use in imaging services. 1 minute standard.
CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	General Activity	For use in imaging services, Baseline time for this activity is 2 minutes.
CA031	Review examination with interpreting MD/DO	General Activity	For use in imaging services, Standard time for this activity is 2 minutes.
CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	General Activity	For use in imaging services, Standard time for this activity is 1 minute.

The PE Subcommittee determined updates to CA006, CA007, CA014, CA030, CA031, and CA032 to simply state: "2 minute standard" or "1 minute standard".

In addition, the Subcommittee specifically discussed the 2 minute standard for CA006. This standard was developed in 2014, and members acknowledged that the review of images using PACS is much quicker, yet the number of images has greatly increased. Thus, two minutes was still found to be appropriate for confirming the availability of prior images/studies.

III. Equipment Inputs Less than $500

CMS definition and rule related to direct medical equipment is that it must be at least $500 and all equipment inputs under $500 are considered indirect expense. The PE Subcommittee discussed that there are eleven equipment items in the current equipment database that are less than the $500 threshold that CMS has established for equipment, as listed below.

Equipment Description	CMS Code	Useful Life	Purchase Price
camera, digital (6 mexapixel)	ED004	5	152.50
Diabetes Educator Curriculum	EQ306	5	200.00
endoscope, ultrasound radial probe	ES045	7	0.00
Injector, Provis (for angiography room)	EL049		0.00
kit, vision	ES058	10	410.00
pulse oxymetry recording software (prolonged monitoring)	EQ212	5	387.00
Respiratory Impedance Plethysmography Belts (pair)	EQ337	5	87.00
Respiratory impedance Plethysmography Belts (pair) (Pediatric)	EQ349	5	199.75
slide warmer	EP051	7	425.59
ultrasound digital scope, endoscopic ultrasound	ES091		0.00
work samples, small tools (Valpar 1)	EQ267	7	361.20

It was surmised that this could be an artifact of the medical supply and equipment repricing project. CY 2022 marked the final year of the 4-year market-based transition for supply and equipment pricing. When the items above were repriced, they should have been removed from the equipment listing when the repricing brought them under the threshold. These items would not be considered supplies as they are reusable. The PE Subcommittee agreed that the equipment inputs listed above should be considered indirect expense like all other equipment under $500.

CMS indicated that it would be open to comments and suggestions for future rulemaking if there is an interest in addressing these equipment items. The Agency noted that "the small number of equipment items with costs under $500 have very low inclusion in CPT codes, aside from ED004, and their costs are so low that they have little effect on the rate setting."

Considering the CMS definition that medical equipment must be at least $500 and all equipment inputs under $500 are considered indirect expense, the PE Subcommittee agreed that the 11 inputs (above) should no longer be listed as equipment as they are less than $500. The RUC should ask CMS to remove these items from its equipment list and from the specific codes to conform to the definition of direct medical equipment and to ensure that the rule remains consistently applied.

IV. Practice Expense Recommendations for CPT 2026

The table below corresponds to the final PE spreadsheets as adopted at the meeting. Please refer to the specific spreadsheets for details on the practice expense input recommendations for each tab.

Tab	Title	PE Input Changes	Consent Calendar
4	Limb Lengthening/Shortening-Femur	No Changes	
5	Limb Lengthening/Shortening-Tibia	No Changes	

6	Laparoscopic Prostatectomy	Standard 90-day global inputs. Oct 2016 & Sept 2014 RUC Recs (38570, 38571, 38572, 38573) – Reviewed & made no changes.	X
7	Transurethral Robotic-assisted Resection of Prostate	No Changes	
8	Prostate Biopsy Services	Modifications	
9	Cerebral Perfusion & CT Angiography – Head & Neck	Modifications	
10	Colon Motility Services	Modifications	
11	Immunization Counseling	Modifications	

AMA/Specialty Society RVS Update Committee **Tab 14**
Relativity Assessment Workgroup
September 26, 2024

Members Present: Doctors Matthew Grierson (Chair), Gregory DeMeo (Vice Chair), Jennifer Aloff, Amr Abouleish, Elizabeth Blanchard, Dale Blasier, Audrey Chun, Daniel Duzan, Patrick Godbey, Harlivleen Gill, MBA, RDN, Martha Gray, Gregory Harris, Greory Nicola, John Proctor, Kyle Richards, Michael Sutherland, and John Thompson.

I. Review Action Plans

High Volume Growth (15272, 20985, 37220-37235, 92507, 95800)
In April 2024, the Relativity Assessment Workgroup identified five codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. The Workgroup requested that the specialty societies submit an action plan for codes 15272, 20985, 61783, 92507 and 95800 for September 2024. CPT code 61783 was deferred until January 2025. Additionally, codes 37220-37235, lower extremity vascular procedures, were referred to CPT in 2018 and the Workgroup requested an update because a coding solution has not yet occurred. The specialty societies submitted a code change application (CCA) for the September 2024 CPT Editorial Panel and the CPT Editorial made additions, revisions and deletions to the LER codes. **The 46 LER codes will be surveyed and reviewed by the RUC in January 2025**.

In September 2024, the Workgroup reviewed the action plans and recommends:

CPT Code	Recommendation
15272	**Remove from screen.** Overall utilization is appropriate. This service is subject to rigorous documentation requirements to maintain coverage eligibility, as outlined in Medicare LCD A54117. Only one provider stands out by submitting almost 100% of the utilization by pain management providers.
20985	**Refer to CPT.** The specialty society would like to address modify the descriptor and address any overlap with codes 0054T and 0055T. It is expected that revising code 20985 will result in a decrease of the reporting of the T codes.
37220 (f) 37221 (f) 37222 (f) 37223 (f) 37224 (f) 37225 (f) 37226 (f) 37227 (f) 37228 (f) 37229 37230 (f) 37231 (f) 37232 (f) 37233 (f) 37234 (f) 37235 (f)	**Survey for January 2025.** In September 2024, the CPT Editorial Panel deleted 16 lower extremity revascularization codes and one Category III code and revised the "Endovascular Revascularization (Open, Percutaneous, Transcatheter) guidelines and parenthetical revisions throughout the code set. The Panel added a new subsection titled, "Iliac Vascular Territory" accompanied by nine new codes; added a new subsection titled, "Femoral and Popliteal Vascular Territory" accompanied by 17 new codes; added a new subsection titled, "Tibial and Peroneal Vascular Territory" accompanied by 16 new codes; and added a new subsection titled, "Inframalleolar Vascular Territory" accompanied by four new codes. **These 46 codes will be surveyed and reviewed by the RUC in January 2025.**

92507	**Refer to CPT** to reflect current practice patterns and modernize the descriptions of treatment services currently captured under CPT code 92507.
95800	**Refer to CPT**. The specialty societies submitted a CCA for Sept 2024 CPT meeting to delete the current code family and replace it with a set of codes that more accurately reflect current medical practice and technologies. However, this tab was withdrawn at CPT due to the many issues identified by the Panel reviewers. The specialty societies indicated that they have drafted a new CCA and plan to submit it for the February 2025 CPT meeting.

Different Performing Specialty from Survey (11305, 11308, 28750, 77280, 94625, 96112)

In April 2024, the Relativity Assessment Workgroup identified six codes where the top two dominant specialties performing services based on 2022 Medicare utilization more than 10,000 and where the top specialty performing over 50% of the Medicare claims did not survey the service or the top two specialties did not survey the service. The Workgroup requested action plans for codes 11305, 11308, 28750, 77280, 94625 and 96112 for September 2024. **In September 2024, the Workgroup reviewed the action plans and recommends:**

CPT Code	Recommendation
11305 11308	**Refer to CPT Assistant** to specifically address correct coding for shaving versus paring and accurate reporting of 11300-11313 versus 11055-11057.
28750	**Survey for January 2025 with applicable family of services.** This service was last valued in 1995, podiatry performs 57% of this service and was not involved in the survey, and this service should be evaluated relative to other services within the family that have changed.
77280	Addressed via CPT. The specialty societies submitted a CCA for the September 2024 CPT meeting. The CPT Editorial Panel added four codes and a new subsection to report surface radiation therapy and deleted codes 77401 and 0394T. The coding changes appropriately describe superficial radiation, performed typically by dermatology. Therefore, Dermatology will report the new services and should no longer report 77280.
94625	**Maintain**. Follow up with this service on the new technology list (April 2026) and review after additional data is available.
96112	**Review in 3 years (September 2027).** A few Nurse Practitioners are performing 40% of these services. Notify CMS that there may be misreporting of this service.

Contractor-Priced High Volume (G0498)

In April 2024, the Relativity Assessment Workgroup identified one code with 2022 Medicare utilization over 10,000 and Medicare status of "C" contractor priced. The Workgroup requested an action plan for G0498 for September 2024. **In September 2024, the Workgroup reviewed the action plan and recommends:**

CPT Code	Recommendation
G0498	**Maintain**. G0498 was created to allow for payment for a **non-implantable** portable infusion pump. CPT code 96416 is for portable or implantable pump. The valuation process does not allow for inclusion of the portable pump expense because the pumps are typically provided through DME rental agreements which represent a rental expense.

High Volume Category III Codes (0552T, 0599T)
In April 2024, the Relativity Assessment Workgroup identified two Category III codes with 2022 Medicare utilization over 1,000. The Workgroup noted that once identified, action plans are requested for the Category III high volume codes. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. The Workgroup requested action plans for codes 0552T and 0599T for September 2024. **In September 2024, the Workgroup reviewed the action plans and recommends:**

CPT Code	Recommendation
0552T	**Maintain** as Category III. Only three NPIs reporting this service the CMS Medicare Physician & Other Practitioners - by Provider and Service 2022 data.
0599T	**Review in 2 years**. Low utilization and the top five providers make up about half of the current utilization in the CMS Medicare Physician & Other Practitioners - by Provider and Service 2022 data.

Work Neutrality CPT 2022 (94625, 94626)
In April 2024, the Relativity Assessment Workgroup identified one issue for codes that were reviewed for CPT 2022 (April 2020, October 2020, and January 2021) that have more than 10% increase in work RVUs from what was projected. The Workgroup requested and action plan Outpatient Pulmonary Rehabilitation Services (94625 & 94626) for September 2024. **In September 2024, the Workgroup reviewed the action plan and recommends to maintain 94625 and 946426 and follow up when they appear on the on the new technology list (April 2026) for review after additional data is available.**

New Technology/New Services

Transcranial Magnetic Stimulation (90867-90869)
At the April 2024 meeting, the Workgroup reviewed an action plan for 90867-90869 and requested to review a new action plan in September 2024 with an update from the specialty society. The specialties indicated that there are changes in protocol for these services and coding changes are necessary. These codes are also contractor priced. The Workgroup questioned what specific coding changes would be included in a CCA. The specialty society will return in September to elaborate on the coding changes necessary. The specialty societies should also consider any Category III codes that are related to these services when drafting their CCA. In September 2024, the specialty societies submitted an action plan requesting that codes 90867-90879 be referred to CPT Editorial Panel to modify the existing codes as well as develop a technology agnostic code or set of codes for the May 2025 CPT meeting/September 2025 RUC meeting. **The Workgroup recommends that 90867-90869 be referred to CPT May 2025 meeting.**

Chronic Care Remote Physiologic Monitoring (99453-99458)
At the April 2024 meeting the Workgroup reviewed an action plan for 99453-99458 and requested to review September 2024 with an update from the specialty societies. A CCA for remote monitoring was reviewed at the September 2024 CPT Meeting which included codes 99453-99458. **CPT codes 99453-99458 will be surveyed and reviewed at the January 2025 RUC meeting.**

Services Performed Together 75% or More (18 code pairs)
In April 2024, the Relativity Assessment Workgroup identified 16 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 2022 Medicare claims data and/or contained at least one ZZZ global service were removed. The Workgroup requested action plans for September 2024 to determine if specific code bundling solutions should occur for the following code pairs. **The Workgroup reviewed the action plans and recommends:**

CPT Code 1	CPT Code 2	Percent Billed Together	Recommendation
13152	17311	76%	**Review in 1 year (September 2025)** to determine if these services are still being reported together more than 75% of the time.
31525	31231	80%	**Review in 3 years (Sept 2027).** Data shows possible misreporting by one practice driving utilization, the specialty society already notified CMS.
31525	69210	75%	**Review in 3 years (Sept 2027).** Data shows possible misreporting by one practice driving utilization, the specialty society already notified CMS.
77301	77300	79%	**Maintain** to allow for continued component coding PC/TC. The physician work is separate, direct practice expenses are separate, the number of units of these two vary so need to maintain separate codes. CPT code 77301 is for planning and 77300 is a dose calculation for each field (some have 3 fields some have 9 fields). Some may report 77301 once but with many 77300 and need to allow for this variation.
77301	77338	88%	**Maintain** to allow for continued component coding PC/TC.
77338	77300	81%	**Maintain** to allow for continued component coding PC/TC.
77338	77301	80%	**Maintain** to allow for continued component coding PC/TC.
77401	77280	77%	Addressed via CPT. The specialty societies submitted a CCA for the September 2024 CPT meeting. The CPT Editorial Panel added four codes and a new subsection to report surface radiation therapy and deleted codes 77401 and 0394T. The family of new codes includes a combination of professional/technical services to allow for the reporting of services performed.
77600	77280	94%	Addressed via CPT. The specialty societies submitted a CCA for the September 2024 CPT meeting. The CPT Editorial Panel added four codes and a new subsection to report surface radiation therapy and deleted codes 77401 and 0394T. CPT codes 77600 and 77280 appear in parentheticals as not to be reported with new surface radiation therapy codes, which will address the bundling issue.
92546	92540	84%	**Refer to CPT.** Revise code 92546 descriptor to clarify the service and it should no longer typically be reported with code 92540, more than 75% of the time. Maintain 92540 and re-review after CPT changes and new billed together data is available (2029).
92550	92557	90%	**Maintain**. Each code provides separate and distinct diagnostic information and the existing construct allows the clinician to select the appropriate test battery based on patient presentation.
92567	92557	85%	**Maintain**. Each code provides separate and distinct diagnostic information and the existing construct allows the clinician to select the appropriate test battery based on patient presentation.
93016	93018	77%	**Maintain**. This code combination is being properly reported through component coding.

95861	95938	86%	**Maintain**. These services do not present duplication in work as there are distinct activities that occur in the pre and post service period which necessitate reporting each individual code.
95921	95923	87%	**Refer to CPT**. The specialty societies submitted a CCA for the Sept 2024 meeting with revisions to the current autonomic function testing code set and the creation of a new Category I code to more accurately reflect current clinical practice and technologies. However, this issue was withdrawn from CPT based on feedback from specialty society comments and Editorial Panel reviewers. The specialty societies will revise the CCA to address concerns with reported together utilization The specialty societies will resubmit a CCA for the February 2025 CPT meeting.
95939	95938	95%	**Maintain**. These services do not present duplication in work as there are distinct activities that occur in the pre and post service period which necessitate reporting each individual code. They are performed on the same day when both the sensory and the central motor pathways need to be evaluated.

II. High-Cost Disposable Supplies Screen

In January 2024, a RUC member suggested that codes with high-cost disposable supplies be flagged for PE re-review. For at least the last 20 years, the RUC has continuously requested that CMS separately identify and pay for high-cost disposable supplies (priced at more than $500). The RUC continues to identify and notify CMS of high-cost disposable supplies every time it reviews such an item.

Additionally, as recent as the January 2024 RUC meeting, *"The PE Subcommittee expressed its continued concern with the issue of high-cost supplies and the outsized impact these items have within the current practice expense RVU methodology.* ***The RUC will continue to call on CMS to separately identify and pay for high-cost disposable supplies (i.e., priced more than $500) using appropriate HCPCS codes."***

In April 2024, the Practice Expense Subcommittee continued to examine this issue. The PE Subcommittee noted that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting.

The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools and how the PE formula derives the code-level indirect practice expense in part as a multiple of the code-level direct practice expense inputs, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty and all other Medicare providers. If high-cost supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services.

In April 2024, the Relativity Assessment Workgroup discussed this issue to determine if a useful screen should be developed to identify any potentially misvalued services. The Workgroup noted that there are significant scaling factors that are applied for budget neutrality as part of the PE methodology, which may result in payments that are lower than the cost to provide a service. The Workgroup indicated that it would be part of existing precedent to identify services for PE review only.

For September 2024, AMA staff pulled the data which show:

- There are 69 services in which the total practice expense payment does not cover the total direct supply expense for the code.
- There are 53 of these 69 services in which a high-cost disposable supply is over $500.
- For 6 of these 53 services, the practice expense payment does not even cover the cost of a single high-cost supply utilized in the provision of the service.

In September 2024, the Workgroup reviewed these services noting that this is a difficult problem to address as there is little input the RUC can provide except pass along paid invoices to CMS for them to price these 82 high-cost disposable supplies. The Workgroup noted that the RUC has iterated that these high-cost disposable supplies need their own supply code, annual review and be paid at cost. However, trying to address via action plans for 157 codes that contain these 82 high-cost disposable supplies may not solve any underlying issues with these services. **Therefore, the Relativity Assessment Workgroup recommends that a joint CPT/RUC Workgroup be formed to address how CMS may address high-cost disposable supplies.**

III. Do Not Use to Validate Physician Work Flag Screen

At the April 2024 RUC meeting, a RUC member inquired about the Relativity Assessment Workgroup (RAW) reviewing codes that are flagged in the RUC database as "Do not Use to Validate Physician Work" to see if these codes warrant a screen for re-review. Two RUC members supported re-visiting the codes that are flagged in the RUC database. This item was referred to the Relativity Assessment Workgroup for further discussion.

The following groupings of rationale for the "do not use" flag were identified:

Do Not Use Flag Rationale	**Number of Codes**
Reallocation of physician time components for PE purposes	169
Surveyed Physician Time Has Not Been Validated by the RUC	61
Molecular Pathology codes, not covered on MFS	44
CMS increased independent of RUC review	37
Other specific flag noted	73
Total	**384**

The Workgroup noted that providing a more granular description of the "do not use" flags in the RUC database would be helpful. AMA staff will work with the Workgroup Chair determine if additional data or screen may be developed based on some parameters for low survey response flagged codes. **The Workgroup will continue this overall discussion at the January 2025 meeting.**

IV. Referral from CPT - Thyroidectomy (60240 and 60260)

At the October 2021, CPT Editorial Panel meeting, the CPT Executive Committee (EC) referrals were presented to the CPT Editorial Panel. The recommendations of the Executive Committee were accepted through a consent calendar, with the following single extraction:

> Tab I: Other Business - Issue 2: Tab 28 - Thyroidectomy 60260 Parenthetical Deletion
> The Panel Chair provided an overview of the issue, which was derived from a previous CPT Assistant Editorial Board recommendation regarding proper coding for CPT code 60260. Specifically, the Editorial Board was seeking clarity on whether the code referred to removal of a lobe of the thyroid, or to removal of all remaining thyroid tissue.

> The AAO-HNS attempted to address this issue via a CCA (Tab 28) submitted for the October 2021 meeting. However, based on additional feedback from the ACS Advisors and Panel reviewers, it was withdrawn prior to the meeting. Given the withdraw, the EC, during their deliberations, discussed potential next steps.
>
> The Panel discussed precedent for sending something back to the RUC. The EC members noted that while this may be rare, it provided an opportunity for the RUC to potentially address an issue that goes beyond just code structure. Furthermore, having the issue tracked as part of a RUC screen/issue may ensure the issue gets addressed through additional mechanisms for tracking and feedback.
>
> The Panel approved the EC recommendation to refer this issue to the RUC to further consider whether CPT codes 60240 and 60260 represent a rank order anomaly.

In July 2024, AMA RUC staff were asked the status of this issue and noted that they missed this referral. The Relativity Assessment Workgroup should discuss this issue at the September 2024 meeting to determine how to address it. **The Workgroup reviewed this referral and recommends that the specialty societies submit an action plan for the January 2025 meeting for CPT codes 60240 and 60260 on how to address these services.**

V. Inpatient Length of Stay

Identifying objective new screens is a charge of the Relativity Assessment Workgroup. Based on other research conducted by AMA staff, inpatient length of stay data and corresponding inpatient hospital visits was identified as a potential screen. AMA staff identified 28 services that are typically performed in the inpatient setting and have more than 10,000 claims in the 2022 Medicare utilization.

An AMA senior economist linked physician Medicare claims data to inpatient Medicare claims data to estimate length of stay for these 28 services. The data utilized was the 2022 Medicare FFS Annual 5% Carrier and Inpatient Claims data. Patients may have undergone multiple procedures during an inpatient stay; thus, length of stay observations in the inpatient file may not solely be attributed to a single procedure code. Also note, that there are no available specific crosswalks between CPT codes and inpatient diagnostic related groups (DRGs).

The estimated length of stay day data for the 28 services does not illustrate any pattern of overestimates of hospital visits included in the surgical global period. It would be difficult to expand this analysis beyond these 28 services due to a lack of an adequate number of observations in claims data. This information is provided to the Relativity Assessment Workgroup to also address the call for the RUC to continue to use all available extant data in evaluating physician services.

The Workgroup reviewed this data and filed it as informational and a responsive effort to seeking out possible uses of extant data.

VI. Informational Items

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

AMA/Specialty Society RVS Update Committee **Tab 07**
MRI-Monitored Transurethral US Ablation of Prostate
Facilitation Committee #2

Members: David Yankura, MD (Chair), James Blankenship, MD, Dale Blasier, MD, Shannon Butkus, PhD, CCC-SLP, Matthew Grierson, MD, David Han, MD, M. Douglas Leahy, MD, Peter Manes, MD, Donna Sweet, MD, G. Edward Vates, MD, Thomas Weida, MD, David Wilkinson, MD

5X006 ***Insertion of transurethral ablation transducers for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed***

The Facilitation Committee reviewed the survey results from 34 radiologists and urologists and determined that a work RVU of 4.05 appropriately accounts for the work required to perform this service. The Facilitation Committee recommends 23 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 29 minutes intra-service time, and 15 minutes post-service time, which equals 82 minutes of total time. The Committee recommends a direct crosswalk to CPT code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU = 4.05, 30 minutes intra-service time and 79 minutes total time). **The Committee recommends a work RVU of 4.05 for CPT code 5X006.**

Additionally, the Committee recommends the following revisions to the materials of this tab:

1. The specialty societies will update their Summary of Recommendations (SORs) to remove the initial statement that CPT code 5X008 could be used by two physicians with the co-surgeon modifier as this code is intended be reported when one physician provides the entirety of this service.
2. The specialty societies indicated they will correct the BETOs assignments in the SORs for the entire family of codes.
3. The specialty societies indicated they will revise the SORs to indicate that suprapubic catheter placement for this family of services is typical.

The Facilitation Committee recommends that CPT codes 5X006, 5X007 and 5X008 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

The Facilitation Committee recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Tab 07 MRI-Monitored Transurethral US Ablation of Prostate Table:

Code	Pre	Intra	Post	Total	Work RVU	Xwalk	Pre	Intra	Post	Total	Work RVU
5X006	38	29	15	82	**4.05**	**52224**	29	30	20	79	4.05
5X007	55	120	27	202	**9.80 (passed at 25th percentile)**	**N/A**					
5X008	70	125	27	222	**11.50 (passed at 25th percentile)**	**N/A**					