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September 13, 2021

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1751-P
P.O. Box 8013 Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

Subject: CMS-1751-P Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on the payment provisions of the above-referenced notice of proposed rulemaking.

EXECUTIVE SUMMARY

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

- The AANS and the CNS are concerned about the overall decrease in the Calendar Year (CY) 2022 conversion factor resulting mainly from discontinuing the 3.75% payment increase included in the Consolidated Appropriations Act, 2021. This will be lowered further by the 2% Medicare sequester and cuts of up to 4% possible under the pay-as-you-go rules if Congress fails to act to prevent these cuts. The AANS and the CNS urge CMS to take all possible action in the agency's authority to provide a positive update to the Medicare conversion factor in 2022.

Evaluation and Management Codes

- **E/M Increases in the Global Surgery Codes.** The AANS and the CNS urge CMS to apply the RUC-recommended changes to the evaluation and management (E/M) component of the 10- and 90-day global surgery codes to maintain the relativity of the fee schedule and to comply with the Medicare law's prohibition on specialty payment differentials.

- **Split/Shared Visits.** The proposed rule defines split (or shared) E/M visits as visits provided in a facility setting by a physician and a non-physician provider in the same group. It states that the practitioner who provides the substantive portion of the visit would bill for the visit. The AANS and

the CNS urge CMS to work with the AMA CPT/RUC Workgroup on E/M Coding to develop consistent guidance on this issue.

- **Critical Care Services.** The AANS and the CNS oppose the limitation of separate reporting of critical care services during the global period and limits on appropriate reporting of E/M codes in combination with these services.

- **Teaching Physician Visit Time.** The AANS and the CNS support the proposal to allow a teaching physician's time to be included when determining the E/M visit level. We also support the proposal that under the primary care exception — which does not require proximity of the attending physician — only medical decision-making may be used to select the visit level.

Practice Expense RVUs

- **Overrides for Practice Expense (PE) Relative Value Unit (RVU) Methodology and Professional Liability Insurance (PLI) RVUs for Low Volume Service Codes.** The AANS and the CNS continue to support using "Expected Specialty Overrides" for low-volume service codes.

- **Update of PE Clinical Labor.** The AANS and the CNS support the agency's plan to update clinical labor pricing to align with the updates for supplies and equipment. We echo comments from the American College of Surgeons (ACS) and the RUC and support a phased-in approach.

- **Clinical Staff Pre-Time Package for Major Surgical Procedures.** The AANS and the CNS support consideration on a case-by-case basis for PE assignment for pre-service clinical staff time for new 000-day global codes or converted from 90-days to 000-days.

CMS Valuation of Specific Codes

- **CMS Should Accept RUC Recommended Values.** The AANS and the CNS recommend that CMS accept RUC-passed values, which are based on valid, clinically relevant information that preserves relativity.

- **Refinement Panels**. Neurosurgery requests that CMS reestablish the refinement panels or a similar process. This would create an objective, transparent and consistently applied formal appeals process that would be open to any commenting organization and provide stakeholders with multiple avenues of appeal.

- **Intracranial Laser Interstitial Thermal Therapy (LITT) (CPT codes 617X1 and 617X2).** The AANS and the CNS urge CMS to accept RUC-recommended values of 20.00 and 24.00 RVWs for CPT codes 617X1 and 617X2.

- **Arthrodesis Decompression (CPT codes 630XX and 630X1).** The AANS and the CNS urge CMS to accept the RUC recommended values of 5.70 and 5.00 RVWs for CPT codes 630XX and 630X1.

- **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion. (CPT code 22867).** The AANS and the CNS were pleased that CMS agreed to accept the RUC recommended value of 15.00 work RVUs for CPT code 22867.

- **Arthrodesis, Anterior Interbody (CPT code 22551).** The AANS and the CNS agree with the agency's decision not to designate CPT code 22551 as misvalued.

Telehealth

- The AANS and the CNS support the agency's proposal to extend coverage of services added to

the Medicare telehealth list in response to the COVID-19 Public Health Emergency (PHE) until the end of 2023. In addition, we ask that CMS continue to permit neurostimulator programming CPT codes 95970, 95971, 95972, 95983 and 95984 on the list of telehealth services after the end of the PHE.

Open Payments Program

- The AANS and the CNS support the CMS proposal for greater transparency for physician-owned distributorships (PODs).

Review of National Coverage Determinations

- The AANS and the CNS generally support efforts by CMS to identify and remove national coverage determinations (NCDs) that are not reflective of current medical practice. To that end, we agree with the CMS proposal to change the NCD for certain positron emission tomography (PET) scans, allowing the Medicare Administrative Contractors (MACs) to determine coverage in their jurisdictions.

Pain/Opioid Provisions

- The AANS and the CNS support patient-centered management of pain by clarifying, communicating, modifying and/or expanding existing care management codes as needed to include patients with chronic pain and significant acute pain, in addition to patients with chronic diseases. In addition, we urge CMS to prohibit Part D plans from imposing prior authorization and quantity limits on buprenorphine.

- The AANS and the CNS urge CMS to finalize its proposal to require electronic prescribing of controlled substances (EPCS) compliance by January 1, 2023, instead of January 1, 2022, and to finalize all proposed exemptions.

QUALITY ISSUES

MIPS Value Pathways (MVPs)

- The AANS and the CNS believe it is premature to consider making MVPs mandatory by 2028, particularly since they do not fix foundational flaws of the program, including the following:

    + <u>Siloed performance categories</u>. CMS must break down the silos that currently result in four disjointed MIPS performance categories — each with a distinct set of measures, reporting requirements and scoring rules.

    + <u>Policies that discourage meaningful participation among specialists</u>. CMS should incentivize the ongoing development and use of a diverse inventory of specific, meaningful measures to physicians and their patients, including scoring policies and better access to Medicare claims data.

    + <u>Inflexible approaches to Promoting Interoperability (PI)</u>. CMS should provide clinicians with the flexibility to demonstrate meaningful use of electronic health records (EHRs) in more innovative ways that account for differences in practice settings, patient populations, infrastructure and experience with health information technology.

    + <u>Ongoing gaps in cost measures</u>. CMS should:

        - Adopt more flexible approaches to cost measurement, including cost measures that do not rely exclusively on claims data;

  - Refrain from using the existing set of total cost of care measures other than for confidential feedback;
  - Demonstrate the relationship between specific cost and quality measures, where feasible, as well as the actionability of the measure before approving a cost measure for MIPS; and
  - Ensure that stakeholder-driven cost measure development is clinician-led and informed by better access to comprehensive Medicare claims and cost performance data.

+ Inappropriate reliance on population health measures. Such data should only be provided to clinicians as confidential feedback.

+ Flawed performance assessment methodologies. Benchmarks should distinguish between practice types — for example, the use of separate benchmarks for small and large practices.

+ Indeterminate glide path to APMs. CMS should better align the reporting requirements of these programs to minimize duplication and inefficiencies and help better prepare clinicians for greater involvement in these APMs. CMS also should identify additional opportunities to better align MIPS with other facility-level quality programs.

+ Ongoing lack of transparency and consultation of relevant clinical stakeholders. To ensure full participation and input from relevant clinical stakeholders, CMS should establish a formal process to ensure transparency and early involvement of all relevant specialty societies when developing MVPs.

Subgroup Reporting

- Although we support the concept of subgroup reporting, the AANS and the CNS oppose the agency's proposal to mandate that multispecialty groups that report MVPs form subgroups starting in 2025.

Traditional MIPS

- Neurosurgery requests that CMS maintain the current performance threshold of 60 points in light of ongoing disruptions to the health care system due to COVID-19.
- CMS should assign a weight of 15% to the Cost category, consistent with how it was weighted before the PHE in 2019.
- The AANS and the CNS support policies that better incentivize the development and use of specialty-specific measures.
- The AANS and the CNS oppose the agency's proposal to increase the data completeness threshold from 70% to 80% in 2023. We also request that CMS consider setting different data completeness thresholds for different types of measures (e.g., patient-reported outcome measures).
- CMS should adopt a more flexible approach to providing information requested under the Provide Patients Electronic Access to Their Health Information measure for the PI category.
- The AANS and CNS oppose adopting the SAFER Guides measure under the PI category. Instead, we ask CMS to consider adding the SAFER Guides as an option under the Improvement Activities (IA) category.

Utilization Data RFI

- CMS should continue to limit the release of utilization data to a downloadable data file that can be used by stakeholders who have the capacity and resources to conduct more technical analyses.

IMAGING APPROPRIATE USE CRITERIA (AUC) PROGRAM

- CMS should continue to delay this program while working with Congress to re-evaluate the feasibility and utility of the program and how appropriate use of imaging can be addressed through the QPP or other value-based initiatives.

DETAILED COMMENTS

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The AANS and the CNS are concerned about the decrease in the CY 2022 conversion factor from $34.89 in 2021 to $33.58 in 2022, mainly due to the discontinuation of the temporary 3.75% payment increase included in the Consolidated Appropriations Act, 2021. This will be further lowered by the 2% Medicare sequester and cuts of up to 4% possible under the pay-as-you-go rules if Congress fails to act to prevent these cuts. Thus, physicians could be facing a 9% payment cut next year.

This is an unsustainable decrease, particularly during the second year of the COVID-19 PHE. Furthermore, Medicare payment rates have failed to keep pace with inflation. The proposed 2022 conversion factor is significantly lower than the rate of $36.6873 paid in 1998 and trending towards the $31.00 in place in 1992 when the fee schedule was first implemented. These looming payment cuts and Medicare's budget neutrality rules must be addressed to ensure that practices remain fiscally viable to provide needed services to patients. **We continue to urge CMS to work with Congress to address the budget neutrality issue and the financial burdens on physicians exacerbated by the COVID-19 pandemic. CMS should exercise its administrative authority to avert or, at a minimum, mitigate these unconscionable payment cuts.**

Evaluation and Management) Codes

- **Failure to Include the E/M Increases in the Global Surgery Codes.** Once again, CMS has inappropriately failed to incorporate the increases in office/outpatient E/M values into the 10- and 90-day global surgery codes — even though the agency did make these adjustments to other bundled services, such as maternity codes, in the CY 2021 Medicare PFS rule. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values into all 10- and 90-day global surgical codes, as evidenced by the many comment letters and meetings over the past several years. The failure to incorporate proportionate increases in the global codes results in an unfair, across-the-board, systematic devaluation of surgical services.

  We reiterate that it is inappropriate that CMS has not applied the RUC-recommended changes to the global codes. The refusal to incorporate the work and time incremental increases for the revised office/outpatient visit codes in the E/M portion of the global surgery codes is entirely unacceptable. Failure to incorporate the increased E/M work in the global codes will:

  + Disrupt the relativity in the fee schedule. Applying the RUC-recommended E/M value increases to the stand-alone office and outpatient visits and select bundled codes that include E/M services (e.g., monthly end-stage renal disease, maternity care and monthly psychiatric management), but *not* also to the E/M portion of the global surgical codes, will disrupt the relativity between codes across the Medicare PFS. Congress mandated this relativity in the

Omnibus Budget Reconciliation Act of 1989, which is the cornerstone of the Medicare PFS as established in 1992 and refined over the past 27 years.

+ Disregard previous precedent**.** Since the inception of the fee schedule, the E/M codes have been revalued four times:

    - In 1993, through refinement after implementation of extensive E/M coding changes;
    - In 1997, after the first five-year review;
    - In 2007, after the third five-year review; and
    - In 2011, after CMS eliminated consult codes and moved work RVUs into the office visit codes.

  Each time payments for new and established office visits were changed, CMS appropriately incorporated these changes into the post-operative visits within the global period. There is simply no valid reason for the agency not to make these same adjustments now, and CMS should follow its own precedent by adjusting the E/M portion of the global codes accordingly.

+ Create specialty differentials**.** The Medicare statute prohibits CMS from paying physicians differently for the same work. According to the law, the "Secretary may not vary the . . . number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." Failing to adjust the global codes is tantamount to paying some physicians less for providing the same E/M services, violating the law.

+ Ignore recommendations endorsed by nearly all medical specialties. In 2019, the RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full, incremental increase of work and physician time for office visits be incorporated into the global codes for each CPT code with a global period of 10-day, 90-day and MMM (maternity). The RUC also recommended modifying the practice expense inputs for the office visits within the global periods. In the CY 2021 PFS proposed rule, CMS used the RUC recommendations as a rationale for increasing the values of the maternity services codes and other select bundled services. However, at the same time, the agency rejected the RUC recommendations related to the global surgery codes. Cherry-picking the RUC recommendations is arbitrary and capricious in violation of the Administrative Procedures Act.

Again, the AANS and the CNS urge CMS to apply the RUC-recommended changes to the E/M component of the global surgery codes to maintain the fee schedule's relativity and comply with the Medicare law's prohibition on specialty payment differentials. Furthermore, we believe CMS has fulfilled its requirement to collect data on global surgery services and, therefore, should cease ongoing efforts to systematically devalue or eliminate the global surgical codes.

- **Reporting of Critical Care Services**. For the sake of coding consistency, CMS proposes to adopt the CPT guidelines for the reporting of critical care services. However, CMS also proposes to bundle critical care with the global surgery period and prohibit the additional reporting of critical care codes during the global period. This is a substantial change from the current policy, which appropriately permits reporting critical care services unrelated to the procedure. CMS also proposes prohibiting physicians from reporting other E/M services on the same date as a critical care visit.

  We strongly oppose this change in current policy, which will prevent surgeons who provide both operative and critical care services from being fairly reimbursed for their time spent legitimately caring for some of their sickest patients. If implemented, this policy would grossly undervalue the care provided by neurosurgeons to some of the sickest patients in the hospital — including those suffering from trauma or stroke. While many surgical patients do not require ICU

care, and ICU care is not included in the value of most 10- and 90-day global codes. However, some patients are either already critically ill when requiring surgery or become critically ill unpredictably after surgery. In these cases, surgeons and surgical intensivists are best equipped to manage the critical care services for these patients postoperatively — particularly since they are familiar with their patient's case and postoperative care needs. They are also most familiar with complex operations and the impact of comorbidities. **Therefore, CMS should maintain the application of modifiers -24 and -25 to indicate that the critical care service can be billed when unrelated to the underlying surgical procedure.**

- **Split (or Shared) Visits.** CMS has asked for feedback on creating a modifier to be reported for split (or shared) visits. **We oppose creating a modifier**, as it would be an additional administrative burden when organized medicine has just established new E/M coding structures and guidelines intended to simplify reporting of E/M services. We suggest that CMS work with the CPT/RUC Workgroup on E/M Coding to create a proposal to present to the CPT Editorial Panel to clarify in CPT Guidelines of split/shared visits.

- **Teaching Physician Visit Time**. **The AANS and the CNS support the CMS proposal to allow a teaching physician's time to be included when determining the E/M visit level and the proposal that under the primary care exception** — which does not require proximity of the attending physician — only medical decision-making may be used to select the visit level. However, we ask the agency to clarify the time that the teaching physician may report. We would support the agency's recognition of the time spent by teaching physicians dedicated to the patient's pathology that may not be specific to the patient's care. We urge the agency to work with the CPT/RUC Workgroup on E/M Coding to clarify and harmonize the instructions for the use of time by teaching physicians to make them easily understood by all stakeholders.

Practice Expense RVUs

As CMS undertakes to review and update PE RVUs, we would like to thank the agency for conducting the June 16, 2021, virtual town hall meeting. We realize that the subject of the meeting is for future rulemaking and not a topic for which the agency has solicited comment for this proposed rule. However, we urge CMS to continue to provide numerous opportunities for stakeholder engagement. We look forward to reviewing future proposals from CMS developed in collaboration with the RUC and others. In the meantime, we offer the following comments on aspects of practice expense relevant to the CY 2022 proposed rule.

- **Overrides for Practice Expense (PE) Relative Value Unit (RVU) Methodology and Professional Liability Insurance (PLI) RVUs for Low Volume Service Codes. The AANS and the CNS continue to support the agency's use of "Expected Specialty Overrides" for low volume service codes with fewer than 100 allowed services in the Medicare claims data**. For a procedure infrequently performed on the Medicare population, low volume status would subject its code to year-to-year fluctuation in the dominant specialty. This creates substantial year-to-year variability in PE RVUs. To address this issue, codes falling into this category are assigned to a dominant specialty based on medical review and input from expert stakeholders. We are pleased that CMS has agreed to work with the RUC to maintain and use the list for both PE and MP RVUs.

- **Update of PE Clinical Labor. The AANS and the CNS support the agency's plan to update clinical labor pricing to align with the updates for supplies and equipment, for which CY 2022 marks the final year of the 4-year transition to the more current pricing**. The clinical labor pricing has not been updated since 2002. CMS proposes to update the clinical labor wage rates according to data from the United States Bureau of Labor Statistics (BLS). This proposal is consistent with our and the RUC's recommendation in comments to last year's proposed rule. CMS has asked whether the update for clinical labor inputs should be phased in. Although neurosurgery

overall is expected to see a modest increase from this policy, we would support a phase in to be consistent with previous CMS policy for changes.

- **Clinical Staff Pre-Time Package for Major Surgical Procedures.** In two separate instances in the Proposed Rule, CMS has changed the facility pre-service clinical labor times for major procedures to conform to the 000- or 10-day global period standards for "Extensive use of clinical staff" despite the RUC recommendation of standard 90-day preservice clinical labor times. **We join the RUC in opposing this policy in general and specifically for Intracranial Laser Interstitial Thermal Therapy (LITT) CPT codes 617X1 and 617X2** described below. Although a procedure may be valued as a 000 day global, when the services are performed under general anesthesia in the facility setting and require specialized supplies and equipment and pre-operative coordination between multiple specialists necessitating office clinical staff time typical of 90-day global procedures performed in the facility setting, this practice expense should be recognized.

  We agree with the RUC when a specialty has provided a strong rationale for pre-service time, CMS should allow for the time regardless of the assigned global period. The agency should recognize that, with supportive evidence, some subset of codes may require extensive use of clinical staff and should permit the RUC-allocated time when appropriate. This is the case with the LITT procedures, for which we provided a robust description of the pre-service work when we presented the codes to the RUC and in our comments on the LITT procedures below.

  A 000-day assignment of a global period for select codes does not negate that a major procedure may require pre-service facility clinical staff time. This requirement is independent of the global period assignment. Each procedure should be evaluated on a case-by-case basis. **We urge CMS to consider the RUC PE Subcommittee's thorough analysis of each code and not automatically prohibit pre-service clinical staff time**. The AANS and the CNS joined the American College of Surgeons and other surgical specialty societies to ask the RUC Practice Expense Subcommittee to review this issue. They have agreed to place the issue on the subcommittee agenda for the October 2021 meeting.

Code-specific Valuation

- **CMS Acceptance of RUC Recommended Values.** While CMS accepted approximately 76 percent of the RUC's work relative value recommendations submitted for CY 2022, we believe the percentage should be higher. We share concerns expressed in the RUC's comment letter to CMS about the agency's use of flawed methodologies — including time ratios and incremental adjustments — to determine code values. This selection process appears arbitrary and allows CMS to select values from the vast array of possible mathematical calculations rather than establishing values based on valid, clinically relevant information that preserves relativity. We are particularly concerned about using these alternative methodologies for the Intracranial Laser Interstitial Thermal Therapy (LITT) CPT codes 617X1 and 617X2 and the Arthrodesis Decompression CPT codes 630XX and 630X1. These codes were valued with exceptionally robust surveys, thoroughly vetted by the RUC and anchored in the Medicare PFS with solid evidence of appropriate rank order valuation. **The AANS and the CNS recommend that CMS improve this process by accepting the RUC recommendations and rationales**.

- **Refinement Panel Process. We request that CMS reestablish the refinement panels or a similar process.** This would create an objective, transparent and consistently applied formal appeals process that would be open to any commenting organization and provide stakeholders with multiple avenues of appeal. We vigorously objected to the agency's elimination of the refinement process several years ago. Despite CMS' contention that refinement was never intended as an appeal or second review, the reality was that having a refinement panel of Carrier Medical Directors, clinical experts and CMS staff to reconsider proposed values did result in appropriate changes. Thus, the refinement panel became a *de facto* appeals process because no other

opportunity existed for appealing CMS decisions. While we have found the change in the timing for publishing proposed values did help with transparency and preparation for changes, this does not obviate the need for a dedicated and transparent appeal process. The AANS and the CNS believe that eliminating the refinement process decreased CMS accountability to its stakeholders. An additional review process would allow specialties to have a full and fair hearing when CMS reduces RUC-recommended RVWs. As such, CMS should reestablish this process.

- **Intracranial Laser Interstitial Thermal Therapy (LITT) (CPT codes 617X1 and 617X2)**

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
617X1	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	19.06	20.00
617X2	multiple trajectories for multiple or complex lesion(s)	22.67	24.00

The AANS and the CNS object to the agency's proposed reduction of the RUC-recommended work values for the new Intracranial Laser Interstitial Thermal Therapy (LITT) — CPT codes 617X1 and 617X2. We support the rationale accepted by the RUC for valuing these new codes and urge CMS to restore the RUC recommended values for the reasons described below.

+ 617X1. CMS agreed with the RUC recommendation for CPT code 617X1 but proposes to apply a formulaic reduction to the work RVU citing the CMS 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy. Under this policy, CMS labels surgical services typically performed in the outpatient setting and requiring a hospital stay of less than 24-hours, as "23-hour stay outpatient services." In the CY 2011 Final Rule, CMS established a policy prohibiting such codes from including the value of subsequent hospital visits (e.g., 99231-99233) as part of the global surgery period. Instead, the agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. In the CY 2011 Final Rule, CMS stated:

> *We are finalizing our proposed approach to valuing 23-hour stay services by allowing the intra-service portion of the subsequent hospital care visits furnished to outpatients in the hospital post-procedure to be allocated to the immediate post-service time of the procedure to account for the physician work in these cases. We encourage the AMA RUC to apply this methodology itself in the recommendations it provides to us for valuing 23-hour stay codes, in order to ensure the consistent and appropriate valuation of the physician work for these services*.

For the past decade, the RUC has honored this policy and reallocated intra-service times accordingly.

The RUC noted that the LITT codes have 000-day global periods, which typically do not allow for an E/M visit on the same day as the procedure. The RUC applied the CMS policy as it relates to the post-service time for the base code. Though the median survey post-service time for code 617X1 was 40 minutes, the CMS 23-hour stay policy was applied, resulting in 60 minutes of immediate post-service time. The intra-service time was reallocated from the same-day E/M code 99232 to the immediate post-service time of the outpatient service — adding 20 minutes of intra-service time from 99232.

To arbitrarily reduce work RVUs, despite a valid survey, is not warranted and was not previously implemented by CMS when other services eligible for the 23-hour stay policy were

reviewed. The AANS and the CNS oppose reductions to work RVUs that disregard the RUC and CMS' long-standing approach of magnitude estimation. This valuation method considers all elements of a service and preserves relativity within the fee schedule for a code family. Magnitude estimation recognizes clinical input and experience through a robust physician survey process. The RUC recommendation for CPT code 617X1 reflects the survey median response from nearly fifty neurosurgeons.

Further, the AANS and the CNS agree with the RUC that using a "reverse building block methodology" to systematically reduce work RVUs for services is inappropriate. Reverse building block methodology, or any other purely formulaic approach, should never be the primary methodology to value services. Magnitude estimation has been the standard to establish work RVUs for services since the establishment of the Medicare PFS in 1992.

The magnitude estimation results of the survey provided the correct rank order for these new neurosurgery codes. We support the RUC's work RVU recommendation and the physician times based upon the survey:

- 113 minutes pre-service time (68 minutes evaluation, 30 minutes positioning, 15 minutes scrub/dress/wait time);
- 180 minutes intra-service time; and
- 60 minutes immediate post-service time, which includes applying the CMS 23-hour stay policy as it relates to the immediate post-service time component.

Therefore, the AANS and the CMS urge CMS to accept a work RVU of 20.00 for CPT code 617X1.

+ 617X2. For CPT code 617X2, CMS agrees with the RUC recommendation of the survey median. However, the agency again inappropriately proposes applying the CMS 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy and a formulaic reduction to the work RVU. As we said above, the AANS and the CNS do not agree with any proposed valuation that uses a reverse building block methodology or any other purely formulaic approach to reduce work RVUs for services systematically.

  In the case of code 617X2, the RUC explicitly noted that, although these codes have 000-day global periods that typically do not allow for an E/M visit on the same day as the procedure, code 617X2 involves a full 2-midnight admission, as reflected by the survey respondents. Therefore, in this case, the work of a same-day E/M visit is justified. Compared to patients undergoing LITT for a single lesion, the complexity of code 617X2 and the level of patient medical instability and risk are more significant. The typical number of "multiple" trajectories is two. Thus in many aspects, the physician work is doubled.

  The AANS and the CNS strongly support the RUC work recommendation and the physician times based upon the survey:

  - 144 minutes pre-service time (93 minutes evaluation, 36 minutes positioning, 15 minutes scrub/dress/wait time);
  - 235 minutes intra-service time; and
  - 40 minutes immediate post-service time and 1-99233 office visit.

  The AANS and the CNS urge CMS to accept a work RVU of 24.00 for CPT code 617X2.

+ Practice expenses for LITT codes. CMS proposes the standard clinical labor times associated with the pre-service time package for 000-day global "Extensive use of Clinical Staff" facility inputs for CPT codes 617X1 and 617X2. The agency notes that the RUC recommended the facility pre-service clinical staff time standards for the 90-day global period

despite surveying these services as 000-day global periods and disagrees with the RUC recommended 90-day times as inconsistent with 000-day services. We echo comments from the RUC, the ACS and others in support of allowing specialties to advocate for the appropriate pre-service time for any given service. The LITT procedures require extensive use of clinical staff. **Therefore, the RUC-recommended pre-service clinical staff time is appropriate for this major surgical procedure.**

As the RUC points out in its comments, CPT codes 617X1 and 617X2 are exclusively performed in the facility setting and require office clinical staff time typical of 90-day global procedures performed in the facility setting. The LITT procedures are performed under general anesthesia. They require specialized supplies and equipment and pre-operative coordination between multiple specialists and the operating room (OR) and the magnetic resonance (MR) imaging suites. The reason these codes were assigned a 000-day global period instead of 90 days is to accommodate the postoperative multispecialty care that is shared (e.g., neurosurgeon, neurologist).

The clinical staff PE inputs for 617X1 and 617X2 were derived from a comparison to CPT code 33361 *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach,* which represents a 000-day global procedure performed by a cardiologist and cardiovascular surgeon. Like the LITT procedures, this procedure also requires additional scheduling and coordination of services between cardiology, cardiovascular surgery, radiology, perfusionist and a specialized anesthesiologist. In addition, the TAVR procedure requires a hybrid OR room with special equipment for the catheter-based, surgical and imaging aspects of the procedure and the cardiopulmonary bypass equipment — all of which must be ordered and coordinated by each physician's clinical staff. Similarly, the LITT procedures require specialized equipment and supplies in both the OR and the MR suites as the patient will have different parts of the procedure performed in each setting.

The recommended clinical staff PE inputs are also comparable to CPT code 61720 *Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus* as this service also requires coordination of a team of specialists and separate rooms (MR and OR suites) for the procedure. This reference code holds a 90-day global assignment yet represents a similar procedure requiring similar pre-service clinical staff work.

In the past decade, several complex procedures have been designated as 000-day global to allow flexibility for multiple clinicians on the care team to care for a patient without being limited by a 90-day global period. However, this does not necessarily affect the pre-service clinical staff time required for the service. Below is a brief description of the clinical staff work involved in the pre-service period for the LITT procedures:

- CA001 (complete pre-service diagnostic and referral forms): The clinical staff will complete pre-service diagnostic and referral forms, including scheduling preoperative clearance and securing insurance prior authorization.
- CA002 (coordinate pre-surgery services): Clinical staff coordination communications between the multidisciplinary team caring for this patient in preparation for the procedure. Preoperative labs and imaging and historical imaging are collected for preoperative planning by the neurosurgeon.
- CA003 (schedule space and equipment in facility): In addition to coordinating all the specialists involved, the specialized supplies, devices, and equipment in both the OR and MR are coordinated and scheduled.

- CA004 (provide education/obtain consent): The patient and family will be educated about the procedure, including the details of affixing the head frame, intraoperative transport and MR positioning, imaging and treatment.
- CA005 (complete pre-procedure phone calls and prescriptions): The patient and family are reminded of the scheduled procedure, given last-minute instructions for prep and reporting for the procedure and confirmation of any required adjustments to medications.

The AANS and the CNS urge CMS to accept the direct practice expense inputs for CPT codes 617X1 and 617X2 as recommended by the RUC, including 60 minutes of pre-clinical staff time.

- **Arthrodesis Decompression (CPT codes 630XX and 630X1)**

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
630XX	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	3.08	5.70 (Final RUC Recommendation submitted May 2021)
630X1	each additional segment (List separately in addition to code for primary procedure)	2.31	5.00 (Final RUC Recommendation submitted May 2021)

In January 2021, the RUC submitted interim recommendations for new CPT add-on codes 630XX and 630X1 based on recommendations presented to the RUC by the AANS, the CNS, the American Association of Orthopaedic Surgeons (AAOS), the International Society for Advancement of Spine Surgery (ISASS) and the North American Spine Society (NASS). The RUC accepted interim values for the codes and asked the specialties to resurvey the new codes with four codes that the RUC deemed "family codes" for presentation at the April 2021 RUC meeting. CPT codes 22630, 22632, 22633, 22634, 630XX and 630X1 were surveyed together, and the recommendations for all six codes were provided to CMS.[1] **We urge CMS to accept the attached final recommendations for CPT codes 22630, 22632, 22633, 22634, 630XX and 630X1**.

+ Background. In discussing the additional level code 630X1, CMS contends, "we do not agree that decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace should have an anomalously high work value in comparison to other similar add-on codes that have longer intra-service times." CMS seems to have forgotten that the valuation of decompression, when combined with interbody fusion, has a long history involving the use of Modifier –62, described below.

  Modifier –62 Two Surgeons: *When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same*

[1] The rationale for the RUC valuation of these codes is attached.

procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

The AANS and the CNS remind CMS that in 1998, the AMA Modifier -62 Workgroup considered whether different specialties should report 22630-62 when physicians of different specialties performed different portions of this procedure. At that time, orthopaedic surgeons routinely performed the interbody fusion, while neurosurgeons performed the decompression. The workgroup decided using modifier –62, *Two Surgeons*, would undervalue the work performed since **22630 did not include the work of a laminectomy and discectomy for decompression. CPT code 22630 only described the bone resection necessary to access the disc space to complete the interbody fusion.** A decompression (63047) performed at the same level would be reported with modifier –51 *Multiple Procedures.* A National Correct Coding Initiative (NCCI) edit effective January 1, 1999, further corroborated the distinct procedure and noted that modifier –59, *Distinct Procedural Service,* should be used if the same surgeon was performing both procedures at the same spinal level. The combined use of the decompression and interbody fusion codes was reiterated in a January 2001 CPT Assistant Article.

In 2010, a new code was developed combining 22630 (arthrodesis, posterior interbody technique) and 22612 (arthrodesis, posterior or posterolateral technique). When the new code — 22633, *Arthrodesis, combined posterior or posterolateral and interbody fusion including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression)* — was surveyed, respondents were instructed that the procedure would not include the work of decompression. **It was understood at this time that the work of decompression would be separately reported and was not included in CPT code 22633.**

There was a misinterpretation of the combined application of these codes by payers that eventually led in 2015 to a NCCI edit, which blocked the use of -59 for 63047 performed at the same level as 22630/22633. Including the decompression work (63047) in the interbody fusion codes (22630/22633) produces a disruptive rank order anomaly in physician work values since this inclusion was not incorporated in the RUC valuations of these codes. National spine societies uniformly opposed this NCCI edit and asked that it be overturned. A CPT Assistant article published in October 2016 offered a similar opinion to the NCCI edit, conflicting with previous CPT and CPT Assistant publications. This article was rescinded by the AMA in another CPT Assistant article published in May 2018. The efforts to correct this error eventually yielded the new interbody decompression codes, 630XX and 630X1. The CMS proposed values for 630XX and 630X1 are considerably lower than the historical values for the codes previously used to report this physician work. The RUC-recommended values are certainly not anomalously high and actually represent a significant decrease in valuation for these services.

\+ 630XX. In the proposed rule, CMS disagrees with the interim RUC recommendation that supports the survey 25th percentile work RVU. The agency suggests that an analysis of other add-on codes with similar time values indicates that this service is overvalued and instead proposes a work RVU of 3.08 based on an intra-service time ratio. The ratio uses the intra-service time (40 minutes) of the interim RUC recommendation and that of CPT code 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in*

addition to code for primary procedure) (work RVU = 3.47 and 45 minutes intra-service time). **The AANS and the CNS strongly disagree with CMS calculating intra-service time ratios to account for changes in time. This approach ignores magnitude estimation and is inconsistent with resource-based relative value scale (RBRVS) principles.**

CMS and the RUC have long held that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system based on relative valuation. When physician times are updated in the Medicare PFS, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of preservice and the length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes. **The AANS and the CNS support the RUC recommendation and urge CMS to continue to account for these nuanced variables**.

CMS disregards the input of 141 neurosurgeons and orthopaedic surgeons and the RUC by proposing to base the work RVU of code 630XX on an intra-service time ratio using CPT code 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure).* CMS claims code 63048 is a stronger reference code due to "similarities in the long descriptors, physician time, and intensity of intra-service work." **However, code 63048 is an inappropriate comparator because of differences in procedure and patient elements**. CPT code 63048 describes the performance of a decompressive laminectomy at an additional level to a base code, 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar*. This procedure involves a significant amount of low-intensity work, including exposure of the adjacent level's bony and soft tissue elements. Code 630XX does not require additional lower intensity work of exposing the bony and soft tissue elements. Instead, the exposure is completed as part of the base interbody fusion code. **Hence, 630XX describes only the high intensity, dangerous aspects of neural element and spinal cord decompression. Therefore, these procedures, while similar, cannot be valued based upon time ratio alone. This approach ignores magnitude estimation and is an overly simplistic approach to valuing this physician service.**

The difference in patient population also argues for a difference in valuation between these codes, as discussed during the RUC assessment of 630XX. Patients undergoing 630XX are considerably more complex, with more severe pathology than those patients undergoing 63047 and 63048. The disease process affecting patients undergoing 630XX is so severe that it requires performing an interbody fusion. This may entail greater degrees of stenosis, greater extent of facet joint arthropathy, spondylolisthesis or greater degrees of degenerative change at the involved segment.

During a CMS discussion with surveying spine specialty societies held on September 10, 2021, CMS inquired whether the RUC surveys of 630XX and 630X1 included 63048 on the reference service list (RSL). RUC processes regarding codes placed on a survey RSL precluded the inclusion of 63048 on the first survey in the Fall of 2020. When the CPT Editorial Panel approved codes 630XX and 630X1 at the October 2020 CPT Editorial Panel meeting, they also made editorial changes to the family of decompression codes. These codes included 63048. The RUC process for surveys does not allow societies to list a code in

an RSL that has been revised and identified as part of "a CPT family of codes" for review/reaffirmation at the same meeting. Therefore, 63048 was not included as a possible reference service for the survey reviewed at the January 2021 RUC meeting.

However, when 630XX and 630X1 were resurveyed with the parent codes of 22630, 22632, 22633, and 22634 for the April 2021 RUC meeting, 63048 was included on the RSL because it was no longer identified as part of the tab/family of services under RUC review. Survey respondents for the April 2021 meeting had the opportunity to select 63048 as a key reference for 630XX. 63048 was not one of the most commonly chosen reference services. When given the opportunity, experienced spine surgeons did not select 63048 as an appropriate comparator for 630XX or 630X1.

The additional work of decompression in these patients, as described by 630XX, is more intense than would be required for 63048. Survey results verify this complexity. While 630XX and 63048 have similar time estimates, 630XX was valued much higher by survey respondents, reflecting how the intensity and difficulty of this service are greater than 63048.

The RUC constructed several valid comparisons to value CPT code 630XX. The RUC compared to the key reference service code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50 and 45 minutes intra-service time) and noted that the reference code has slightly higher intensity as anticipated for a surgical procedure and in comparison, with a lumbar procedure. The RUC also compared code 630XX to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm. In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code. The intra-service time includes higher intensity bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, although both codes require the same time, the physician work and intensity of 630XX is greater than 34812.

CMS notes that the proposed work RVU for CPT code 630XX falls between CPT code 19294 *Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy* (work RVU = 3.00 and 40 minutes intra-service time) and CPT code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* (work RVU = 3.28 and 40 minutes intra-service time). **These are inappropriate comparison codes because neither reflects the complexity of 630XX**. Code 19294 describes the additional soft tissue work required for delivery of radiation therapy after partial mastectomy. This code is routinely reported concurrently with a separate code for the work of the radiation oncologist. This code describes only soft tissue dissection, and the physician work does not involve dissection around neural elements and around the spinal cord. The physician work of code 19294 has a lower intensity than code 630XX. Similarly, code 37185 describes mechanical thrombectomy, arterial or arterial bypass graft, for second and adjacent vessels. This work does not entail risk to neural elements or the spinal cord; it is considerably lower intensity than 630XX.

The AANS and the CNS strongly urge CMS to respect the expertise and judgment from practicing physicians when valid surveys are conducted, rigorous review by the specialty society committees is performed, and the RUC has conducted an accurate analysis of magnitude estimation and cross-specialty comparison. **The CMS proposed value represents an unacceptable 45 percent reduction from the interim RUC recommendation as submitted — particularly since the agency is not using a valid method to establish work RVUs for CPT code 630XX using a value based on an intra-service time ratio.**

The RUC re-reviewed CPT code 630XX in April 2021 and recommends a work RVU of 5.70 based upon the recent survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons. The RUC determined that the survey 25th percentile appropriately accounts for the physician work involved in this add-on service. The final recommendation is more accurate than the interim as it is based on the survey of the entire code family. In addition, the overall experience of the survey respondents is greater for the new survey of six codes when compared to the prior survey of only the add-on codes. The RUC recommends 45 minutes of intra-service time and explains that the time included in this add-on service is essentially all high-risk, higher intensity work. The lower intensity surgical exposure activities have already been completed with the base code, so the physician work of 630XX involves the actual higher intensity decompression. **Therefore, the AANS and the CNS urge CMS to accept a work RVU of 5.70 for CPT code 630XX.**

\+ 630X1. CMS proposes a work RVU of 2.31 for CPT code 630X1 based on an intra-service time ratio between the proposed 30 minutes of intra-service time for CPT code 630X1 and the proposed 40 minutes of intra-service time for CPT code 630XX. While the RUC recommended, on an interim basis, that CPT code 630X1 should be valued based on a direct crosswalk to CPT code 33572 with 30 minutes intra-service time as supported by the survey, CMS again uses an intra-service time ratio in justifying the proposed value. **The AANS and the CNS strongly disagree with CMS calculating intra-service time ratios to account for changes in time.** Instead, we acknowledged the robust survey results and the RUC determination that a value below the 25th percentile was appropriate given the time for code 630X1 was three-fourths that of the 630XX code.

CMS brackets its proposed work RVU for CPT code 630X1 between CPT code 43273 *Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)* (work RVU = 2.24 and 30 minutes intra-service time) and CPT code 22870 *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level* (work RVU = 2.34 and 30 minutes intra-service time). The agency notes that both of these reference codes have identical intra-service times as CPT code 630X1. Code 43273 is an add-on code designed for addition to base codes describing endoscopic retrograde cholangiopancreatography (ERCP). This procedure does not involve dissection around neural elements and the spinal cord. Its only relevance to 630X1 is a comparable intra-service time. It is not an appropriate crosswalk. Code 22870 — while a spine procedure — specifically does not involve decompressing neural elements or the spinal cord. Thus, its intensity is much lower than 630X1. The base code that CPT code 22870 is routinely appended to — code 22869 *Insertion of interlaminar/ interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level* — is an outpatient code. In contrast, the base codes for 630XX and 630X1 are all inpatient codes. It is assumed that the pathology of patients undergoing codes 22869 and 22870 is less severe than those patients undergoing interbody fusion (22630/22633) with concomitant lumbar decompression (630XX and 630X1). Therefore, this CMS-recommended code is also a poor crosswalk.

The AANS and the CNS support the brackets constructed by the RUC, for CPT code 630X1, with identical intra-service time, using comparator codes 32674 *Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)* (work RVU = 4.12 and 30 minutes intra-service time) and 33924 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)* (work RVU = 5.49 and 30 minutes intra-service time). The RUC notes that CPT code 32674 is a minimally invasive procedure to identify and remove lymph nodes in conjunction with a single lobe lobectomy. The technical skill and mental effort/judgment for 630X1 is greater due to the involvement and necessary protection of spinal cord and neural elements. CPT code 33924 is more intense than 630X1 and thus appropriately valued higher.

CMS is not using a valid method to propose a work RVU for code 630X1 by proposing a value based on an intra-service time ratio. Moreover, the proposed value represents an unacceptable 48% reduction from the interim RUC recommendation as submitted.

The RUC re-reviewed CPT code 630X1 in April 2021 and recommends a work RVU of 5.00 based upon the recent survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons. The RUC determined that the survey 25th percentile appropriately accounts for the physician work involved in this add-on service. The final recommendation is even more accurate than the interim value as it is based on the robust survey results rather than a crosswalk. The new survey, which included all six codes, elicited an intra-service time of 40 minutes that is only five minutes less than the work related to 630XX and is a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and an additional segment. **The AANS and the CNS urge CMS to accept the RUC recommended work RVU of 5.00 for CPT code 630X1.**

- **CPT Code 22867.** We were pleased to see that CMS has agreed to accept the RUC-recommended value for CPT code 22867. The agency had received requests to consider as potentially misvalued, CPT code 22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level*, last year. The AANS and the CNS agreed that the code was misvalued, but a new survey was unnecessary since two RUC surveys had already been conducted for the code. However, we urged the agency to review the history of the RUC recommendation for the code, rather than requiring the time, expense and effort involved in a new survey. Therefore, **we appreciate CMS restoring the RUC-recommended values of 15.00 RVWs for this procedure**.

- **CPT Code 22551.** CMS notes that on February 2, 2021, LifeNet Health — a manufacturer of allograft bio-implants — nominated as misvalued, CPT code 22551, *Arthrodesis, anterior interbody, including disc space preparation, discectomy*. In the 2022 proposed rule, CMS disagreed with the company's analysis and will not designate the code as misvalued. **We agree with the agency's contention that the company has not provided a convincing argument for questioning the code's valuation, and it should not be considered misvalued**.

Open Payments Program

CMS is proposing several changes to the Open Payments Program, which requires manufacturers to report payments in three categories:

1. General (for items such as food and travel);
2. Research; and
3. Ownership interest.

For CY 2022, CMS proposes a specific definition for physician-owned distributorships (PODs) and will implement an explicit requirement for PODs to be clearly and separately identified. The AANS and the CNS support transparency and disclosure of potential conflicts of interest in our ethical codes. **Therefore, the AANS and the CNS support the agency's plan to include a specific definition of PODs and require PODs to self-identify and report to Open Payments**.

Review of National Coverage Determinations

CMS has established a process for removing outdated NCDs (i.e., those 10 years or older), allowing local MACs to determine coverage previously governed by an NCD. In general, we support the agency's efforts to identify and remove NCDs that are not reflective of current medical practice and agree with the agency that the local MACs may be better able to assess new technology as it develops across the country — provided there is improved coordination among the local carriers. Unfortunately, we continue to have some concerns about how the MAC multi-jurisdictional Carrier Advisory Committees (CACs) have been used in the last few years.

For example, in the recent review of percutaneous vertebral augmentation for compression fractures, the MACs conducted a multi-jurisdictional CAC meeting. Subsequently, however, the MACs each issued separate but identical local coverage determinations (LCDs) that ignored many of the stakeholders' comments from the CAC meeting. The LCDs all had different comment periods, requiring interested specialty societies to submit separate but virtually identical comments to each MAC and make seven individual formal requests for reconsideration. While some of the MACs ultimately issued reasonable LCDs for this particular procedure, it points out the need for better coordination and oversight of the LCD process.

As for the CY 2022 proposed rule, CMS recommends discontinuing certain provisions of the NCD for PET Scans and giving greater discretion to local Medicare Administrative Contractors (MACs). The AANS and the CNS support this change.

Expansion of Telehealth

CMS does not propose to add any new services to the list of reimbursable telehealth services. However, CMS proposes to extend reimbursement for certain telehealth services added during the COVID-19 Public Health Emergency to the end of 2023. **The AANS and the CNS support the proposal to extend coverage of services added to the Medicare telehealth list on an interim basis in response to the COVID-19 PHE until the end of 2023**. However, CMS has proposed not to extend coverage of Neurostimulator Analysis and Programming — CPT codes 95970, 95971, 95972, 95983 and 95984 — after the PHE. Although we were initially unsure about the performance of these codes through telehealth, physicians and patients have found them helpful. In addition, since the start of the PHE, new technology has been introduced and approved by the FDA that allows full remote programming of certain neurostimulator devices with real-time audio-visual connection. **This further supports the long-term inclusion of these neurostimulator and programming codes as eligible for telemedicine visits. Therefore, we urge CMS to continue to permit their use via telehealth after the end of the PHE**.

Pain/Opioid Provisions

The AANS and the CNS are active participants in helping address the nation's opioid crisis. Furthermore, many of our members treat chronic and acute pain. As members of the AMA Task Forces on Pain and Opioid Prescribing, we echo the group's comments on the CY 2022 Medicare PFS provisions related to pain and opioids. **We agree with the AMA that CMS should end policies that simply evaluate pain treatment quality based on opioid prescription numbers and Milligram Morphine Equivalence (MME) rather than on more meaningful measures to assess the well-being of patients**. We support patient-centered management of pain by clarifying, communicating, modifying,

and/or expanding existing care management codes as needed to include patients with chronic pain and significant acute pain, in addition to patients with chronic diseases.

Further, **the AANS and the CNS urge CMS to prohibit Part D plans from imposing prior authorization and quantity limits on buprenorphine.** In addition, although not part of the Medicare PFS regulation, **we continue to object to the requirement for prior authorization under the Medicare Hospital Outpatient Department (OPD) regulations for opioid-sparing treatment such as spinal cord stimulation and anterior cervical fusion.** These prior authorization burdens are contrary to CMS' stated goal of reducing opioid prescriptions. Non-pharmacological treatment by neurosurgeons for Medicare beneficiaries with chronic pain offers significant improvement in appropriately selected patients

Finally, we offer comments regarding the electronic prescribing of certain controlled substances (EPCS). The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act requires electronic prescribing of certain controlled substances covered through Medicare Part D. CMS is proposing some exceptions and a one-year delay in implementation. Exceptions would be made for prescribers who write 100 or fewer controlled substance prescriptions in a calendar year and those in the geographic area of a natural disaster or who are granted a waiver based on unusual circumstances. **The AANS and the CNS agree with the agency's proposed exceptions for EPCS.** We recently were made of reports that the SUPPORT Act has been misinterpreted due to a potential unintended consequence of Section 3204 of the law focused on dispensing controlled substances for the maintenance or detoxification of opioid use disorder. This section's legislative intent and purpose were to help increase access to implantable and injectable prescription forms of medications to treat opioid use disorder (MOUD) by allowing pharmacies to distribute these medications to physicians directly for administration to their patients. However, some Drug Enforcement Administration (DEA) staff have expressed concern that this provision of the SUPPORT ACT means that distribution by pharmacies to physicians would be limited to MOUD and that long-standing treatment protocols for physicians obtaining pain medication for their patients with intrathecal pumps would be prohibited. Although we realize this may require legislation to address, we bring it to your attention as we are concerned that patients may experience a sudden inappropriate limit to intrathecal therapy. **The AANS and the CNS urge CMS to collaborate with the DEA to facilitate ongoing access to intrathecal therapy.**

QUALITY ISSUES

MIPS Value Pathways (MVP)

The MVP framework aims to streamline MIPS reporting, reduce clinician burden, and provide a glide path to APM participation. After delaying implementing the MVP framework in previous rulemaking, CMS is now proposing to introduce seven MVPs for voluntary reporting beginning with the 2023 Quality Payment Program (QPP) performance year. CMS also expresses interest in phasing out the traditional MIPS pathway and making MVPs mandatory beginning with the 2028 performance year.

The AANS and CNS support the MVP framework's goal of moving towards more cohesive sets of measures and activities that focus on specific specialties, conditions, or patient populations and result in a less burdensome program and more meaningful to both patients and physicians. However, we are concerned that the framework does not resolve foundational issues that have limited meaningful clinician engagement in MIPS and have hampered meaningful progress towards higher quality and higher-value care. Instead, the framework seems little more than a continuation of MIPS specialty measure sets with a slight reduction in reporting burden. **In light of these concerns detailed below, the AANS and CNS believe it is premature to consider making MVPs mandatory by 2028. Instead, we urge CMS to continue working with stakeholders and Congress to identify more appropriate and feasible ways to promote high-value care.**

- **Siloed Performance Categories**. The current MVP framework lacks a cohesive, streamlined approach to holding physicians accountable for improving the quality of care, leveraging technology, and reducing avoidable costs. **To truly streamline the program, CMS must take more concrete steps to break down the silos that currently result in four disjointed MIPS performance categories with a distinct set of measures, reporting requirements and scoring rules**. Clinical actions captured by measures and activities, such as reporting to and receiving feedback from a clinical data registry, should translate into credit across multiple performance categories to unify the program and minimize administrative burden. For example, rather than clinicians having to separately attest to IAs as part of their MVP reporting, the developer of each MVP could indicate to CMS which IAs clinicians are inherently performing as part of a particular MVP, and corresponding IA credit could be automatic — similar to how MIPS APMs and patient-centered medical homes are now scored in the IA category. The current siloed structure, which remains under the MVP framework, makes the program challenging to navigate and unnecessarily resource-intensive.

- **Policies Discouraging Meaningful Participation**. MIPS participation options, scoring rules, and qualified clinical data registry (QCDR) policies continue to disincentivize the development and use of more clinically focused measures and participation pathways that result in meaningful improvements in care.

    + Subgroup reporting. Currently, there is little correlation between program compliance and the actual quality of patient care. MIPS participation occurs at the group practice (TIN) or APM Entity level for many surgical specialists — specifically, through large, multi-specialty institutions or health systems. These entities employ administrative staff whose role is to identify the path of least resistance — i.e., how to comply with the program in a manner that imposes the lowest reporting burden while producing the highest performance for the group or entity. This results in selecting measures that are rarely relevant or meaningful to neurosurgeons in the group or their patients (e.g., blood pressure management, smoking cessation, immunization measures, etc.). For example, a recent search on Care Compare for a neurosurgeon associated with a large academic center and ACO produced a MIPS performance report that displays performance on measures related to pneumococcal vaccines and breast and colorectal cancer screenings. It also showed poor performance on EHR metrics reflective of the group rather than the individual specialist. This neurosurgeon recently won an award from his hospital for communicating patient information during referrals and transfers of care. Yet, the public report ties him to one out of five stars on that measure. As a result, this public performance report provides absolutely nothing of value or accuracy to a patient searching for a quality neurosurgeon.

      In the current environment, our members have little control over MIPS participation options and are largely disconnected from the program. Even when more relevant neurosurgical measures are available, it has been challenging to convince institutions to expend the resource to report these measures for purposes of MIPS. **The AANS and CNS appreciate CMS proposing in this rule to make subgroup reporting an option for MVP participants starting in 2023 since this policy is intended to provide a pathway for specialists to select measures most relevant to their patients. However, as discussed in more detail below, if CMS simultaneously maintains policies that also disincentivize the development of more granular and patient-centric measures and the use of more relevant data collection mechanisms (i.e., QCDRs), then the subgroup reporting option will fail to have a positive impact on the program and will instead make it even more complex and burdensome.**

    + Scoring policies. CMS proposes to further disincentivize specialty-specific measures by proposing to assign measures that lack a benchmark of zero points rather than 3 points. This

will result in even fewer clinicians selecting historically unused measures and the near-term removal of these measures from the program. While we appreciate CMS proposing a 5-point floor for "new" measures during their first two years in the program, beginning with the CY 2022 performance period, this proposal does nothing to address the numerous measures that have been in the program for many years now, but continue to lack a benchmark and are at risk for removal. There is simply no incentive to report on these measures since they would put clinicians at a major scoring disadvantage, particularly since CMS raises the MIPS performance threshold each year. Unfortunately, these policies would also apply to the MVP framework, which means that MVPs would do nothing to resolve these disincentives. **As CMS implements the MVP framework and particularly considers adopting a sub-group reporting mechanism, as discussed below, it must incentivize the ongoing development and use of a diverse inventory of specialty- and sub-specialty measures that are meaningful to both physicians and their patients. Instead of allocating zero points for existing measures with no benchmarks, CMS should provide credit to clinicians who take the time to report on more focused measures and contribute to building performance benchmarks.** Infrequent use of a measure is not necessarily indicative of low value but rather program policies that disincentivize the use of the measure. **The AANS and the CNS also encourage CMS to consider raising the floor for reporting on new measures (as well as existing measures with no benchmarks) to a minimum of 7 points, particularly if CMS simultaneously increases the performance threshold.**

+ Specialty-specific measures. We are also concerned that recent CMS policy decisions related to QCDR measure testing and data validation have made this an impractical and unattractive option for many specialty societies. While QCDRs were supposed to offer specialists a pathway to introduce more focused and potentially innovative measures, the experience has been so disappointing that numerous prominent specialty society registries have decided that it is not a worthy investment. After almost two years of development work and within months of implementing neurosurgery's specialty-specific QCDR measures, CMS — in what seemed like an attempt to reduce its administrative burdens — began to water down the measures to the point that they essentially became generic. The effort was branded as an efficient "consolidation" of QCDR measures by CMS. However, the process became a "regression to useless previously existing measures" rather than promoting more robust measures, many of which captured patient-reported outcomes. Even if CMS provides substantive incentives for the application of meaningful measures, such as through the subgroup reporting option, we would need reassurances that CMS would not just turn around and execute the same deconstruction of robust measures with every specialty society that goes through the time and expense of designing, validating and approving these more focused measures.

In short, **we are concerned that CMS seems to be reverting to a one-size-fits-all approach to measurement and strongly urge the agency to reverse course if it wishes to truly move the needle on quality and produce more meaningful data for patients**. When CMS discusses the complexity of MIPS, it is quick to point out that clinicians are overwhelmed by the large inventory of measures. We dispute that assertion and believe it is misinformed. The programming complexity that most overwhelms our members has to do with the four separate performance categories. Each has its own reporting and scoring rules and the nuanced requirements and goalposts that shift from year to year. Perhaps more importantly, it is the waning diversity of the measure inventory and program policies that fail to promote more specialized and impactful measures that result in our members feeling so disconnected from the program.

It also has been challenging for specialty societies to propose strong, scientifically sound, risk-adjusted outcomes and cost measures due to limitations on access to Medicare claims

data, particularly for specialty societies that wish to supplement claims with clinical registry data, as discussed below. **The AANS and the CNS urge CMS to provide specialty-specific and condition-specific Medicare claims data, MIPS cost performance data and funding to help specialty societies develop new measures as part of MVPs.**

- **Inflexible Approaches to Promoting Interoperability (PI).** In the CY 2021 PFS final rule, as a part of the MVP development criteria, CMS finalized that MVPs must include the full set of PI measures, including the category's all-or-nothing scoring methodology. **The AANS and CNS again urge CMS to provide clinicians with the flexibility to demonstrate meaningful use of EHRs in more innovative ways that account for differences in practice settings, patient populations, infrastructure and experience with health information technology.** The MVP framework does nothing to move beyond the one-size-fits-all approach. It continues to rely on measures that focus on the functionalities of certified electronic health record technology rather than genuine improvements in patient care. To realize the full potential of EHRs, requirements under this category need to be less prescriptive and more diverse. Clinicians should have the opportunity to demonstrate the various ways that they are capturing, applying and sharing electronic data to improve patient care, including the:

  + Implementing practice improvements based on patient-generated electronic health data;
  + Participating in clinical registries that seamlessly incorporate EHR data;
  + Using clinical decision support tools; and
  + Adopting electronic platforms and apps that allow clinicians to communicate with patients better.

- **Ongoing Gaps in Cost Measures**. Many of the proposed MVPs continue to rely on the total cost of care measures — including the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost measures — because more focused episode-based cost measures are not yet available. While we appreciate the agency's interest in promoting team-based care and preparing clinicians for the more population-level measurement that occurs under APMs, the total cost of care measures hold clinicians accountable for care that is often beyond their direct control and has limited value ability to impact care coordination in a clinician-focused accountability program. The MSPB measure, in particular, was initially developed for hospital-level accountability. However, it results in very little actionable data for individual clinicians seeking to manage resource use better when used under MIPS. **As CMS continues to develop more focused episode-based cost measures, we request that the agency refrain from using these total cost of care measures other than for confidential feedback.**

  Regarding episode-based cost measures, the AANS and the CNS appreciate that CMS and Acumen continue to consult relevant clinical experts, including our members, when developing these measures. Nevertheless, we remain concerned that the current inventory of episode-based cost measures is not directly associated with existing quality measures, limiting the agency's ability to evaluate overall value accurately. This becomes even more evident as CMS attempts to assemble MVPs centered around a specific condition or specialty. For example, the Stroke MVP includes some quality measures that focus on surgery but an episode-based cost measure that focuses on medical management of the stroke patient. As a result, the MVP will produce an incomplete and inaccurate assessment of value related to the individual surgeon or surgical practice, which is only responsible for a specific portion of the patient's stroke care. When cost measures are applied in isolation and have no direct tie to quality, they may disincentivize proactive, high-value care that might have some cost, but that improves patient outcomes and avoids potentially higher future costs. They also could have the unintended consequence of incentivizing clinicians to skimp on care and avoid risky patients. **Before approving a measure for MIPS, CMS should be required to demonstrate the relationship between specific cost and**

quality measures, where feasible, to avoid rewarding cost savings at the expense of quality, as well as the actionability of the measure.

The AANS and CNS remind CMS that cost measure gaps could be filled more rapidly if the agency were willing to consider other alternatives, in addition to episode-based cost measures. **We strongly urge CMS to allow for more flexibility regarding cost measures, such as considering appropriateness of care measures that may have more of a direct association with quality. Cost measures also should not rely exclusively on claims data.** While claims may be an important source of data, we urge CMS to consider supplemental sources of data that can enhance cost measures, including clinical registry data. In many cases, the critical information that distinguishes differences in patient needs is not captured in claims data, particularly regarding disease severity, so clinical data will also be required (for both cost and quality measures).

Finally, the AANS and CNS appreciate that CMS recognizes the critical need to fill ongoing gaps in cost measures by proposing a process for developing cost measures by stakeholders outside of the current development process, beginning in 2022. **For this to succeed, it is absolutely critical that the process is clinician/specialty-society-led to minimize the potential for contractors or other third parties to develop cost measures without adequate input from those with clinical and methodological expertise. CMS should also encourage developers to demonstrate the relationship between specific cost and quality measures, where feasible, as well as the actionability of the measure. Furthermore, CMS must provide more comprehensive Medicare claims data and cost performance data to specialty societies and funding and technical support to help specialty societies identify and develop clinically appropriate cost measures.** As we have noted in the past, the current processes for obtaining Medicare claims data, such as through ResDAC, are time-consuming, expensive and impractical. Additionally, the provision of more specialty-specific and condition-specific cost performance data — similar to what CMS provided in the past through the Physician Quality Reporting System Experience Reports and Quality and Resource Use Reports would help specialty societies better understand and target remaining gaps in cost measures.

- **Inappropriate Reliance on Population Health Measures**. As noted above, in the context of the total cost of care measures, the AANS and CNS support shared accountability and team-based approaches to care. However, the population health measures hold neurosurgeons accountable for aspects of care that are outside of their direct control. While there may be a role for population health measures in an APM or a facility-level quality program, these types of measures simply do not align with clinician-level accountability tied to fee-for-service payments. For example, during the National Quality Forum's recent review of the All-cause Unplanned Admission for Multiple Chronic Conditions for MIPS measure — which is being proposed as a foundational population health requirement for MVPs — it was noted that although improved care coordination and care management can lead to reductions in hospital admissions, these efforts required the involvement of multiple partners such as a disease management program, health system, and/or hospital. We also remind CMS that social determinants of health have a much stronger influence on these metrics than clinical care. As such, we do not believe that physicians or practices, in the absence of some coordinated program or payment offset (e.g., care management fee), can implement structures or processes that can lead to improved outcomes for these patients.

  Population health measures are also outside of the intent of the Medicare Access and CHIP Reauthorization Act (MACRA) legislation. They seem to deviate from CMS' goals of incorporating the patient's voice, measuring clinical conditions and outcomes and generating more actionable real-time feedback. **If CMS insists on using these types of measures, then the resulting data should only be provided to clinicians as confidential feedback.**

- **Flawed Performance Assessment Methodologies**. Under the MVP framework, CMS would continue its flawed approach of setting benchmarks that lump all physicians together regardless of specialty, location, practice size or patient population. This approach does not provide physicians or patients with meaningful or accurate information to distinguish between high-quality or poor care. **Benchmarks should distinguish between practice types — for example, the use of separate benchmarks for small and large practices.**

- **Indeterminate Glide Path to APMs**. CMS continually promotes MVPs as a way to prepare clinicians for APM participation. However, the current MVP framework does little to create a practical glide path for surgeons to transition to APMs seamlessly. For example, The Society of Thoracic Surgeons (STS) recently worked with the Center for Medicare and Medicaid Innovation (CMMI) to incorporate STS registry measures into the Bundled Payment Care Initiative (BPCI) Advanced APM Coronary Artery Bypass Grafting (CABG) and Cardiac Valve episodes. However, participants in BPCI-Advanced who do not participate in the model at a sufficient level to qualify for the APM incentive payment and an exemption from MIPS cannot get credit under MIPS for the quality measures they are already reporting under BPCI-A.

  Similarly, many of our members report quality measures under the BPCI-Advanced Spinal Procedures episodes, such as the Perioperative Care: Selection of Prophylactic Antibiotics measure and the Advance Care Plan measure. These align with MIPS measures, yet must be reported separately under each program. **We strongly urge CMS to identify ways that it can better align the reporting requirements of these programs to minimize duplication and inefficiencies and help better prepare clinicians for greater involvement in these APMs. Similarly, we request that CMS work with stakeholders to identify additional opportunities to align MIPS more closely with other facility-level quality programs.** Many specialists are already contributing data to those programs, and those programs more closely represent the shared accountability and team-based approaches APMs.

- **Ongoing Lack of Transparency and Consultation of Relevant Clinical Stakeholders**. The AANS and the CNS also have concerns about how CMS has conducted MVP development with stakeholders to date. Although we provided feedback during the development of the draft Spine MVP, and appreciate CMS taking our advice to not move forward with that MVP at this time, we were not initially contacted by CMS to assist with the development of this MVP and only found out about it through another specialty society. Similarly, we were not consulted at all in the development of the Stroke MVP, despite the significant contributions of neurosurgeons to the treatment of stroke patients in the acute care setting. **To ensure participation and input from relevant clinical stakeholders, we recommend that CMS establish a formal process to ensure transparency and early involvement of all relevant specialty societies in the development of MVPs.** For instance, CMS could publish a list of MVPs under consideration on the QPP website and the MVP developer to contact for coordination. It is also critical that CMS adopt a formal criterion to ensure that MVP development is clinician-led. This should also provide clear and timely feedback about why a candidate MVP submission might not have been proposed for implementation.

- **Subgroup Reporting.** As part of the MVP framework, CMS also proposes a subgroup reporting option that would be voluntary for the 2023 and 2024 performance years. However, starting in 2025, if a multispecialty group would like to report MVPs, they could only do so if they form subgroups. CMS anticipates that at a future time when subgroup reporting is mandatory, there will need to be criteria to determine which specialty is a primary specialty of clinicians and potential limits around how clinicians can participate and be assessed as subgroups. One consideration is to limit clinicians in multi-specialty groups to participate through single-specialty subgroups. However, at this time, CMS is not putting limitations on which specialty will be considered the primary specialty for purposes of subgroup reporting.

The AANS and CNS agree with the goal of the subgroup reporting proposal, which is to allow clinicians to report and be assessed on measures and activities that are most meaningful to their practice. As noted earlier, current program policies encourage large multispecialty groups and institutions to report on measures that are not relevant or meaningful to all specialists in those groups. At the same time, specialty societies that have invested in the development of better measures through the QCDR pathway have not been able to keep up with the resources required to maintain those measures, have been forced to water down measures to the point of it not being worth the investment, and have faced program disincentives for groups and facilities to invest in those registries. As a result, specialists such as neurosurgeons lack MIPS results that can lead to data-driven improvements in quality. At the same time, their patients are denied the granularity of data needed to make informed healthcare decisions. Subgroup reporting may potentially produce more clinically relevant, actionable and valuable data, but only if paired with policies that simultaneously incentivize the development and use of more meaningful measures and more focused reporting mechanisms. Otherwise, subgroup reporting will only add another layer of complexity and administrative burden to an already unworkable program.

Given these unresolved issues and concerns about the sizeable administrative burden that subgroup reporting could create for multi-specialty practices, the AANS and CNS oppose the agency's proposal to mandate that multispecialty groups that report MVPs form subgroups starting in 2025. As we look to the future — where advances in technology and interoperability may allow for the automatic calculation of clinician performance with little manual entry; where we may have developed more reliable prospective attribution methodologies that directly drive improvements in care; where there may be better alignment of measures across care settings and APMs; and where CMS policies may better support the development and use of more meaningful measures — it may be more appropriate to consider mandatory subgroup reporting. However, it is premature for CMS to finalize this requirement at this time without yet knowing the future landscape. We also advise against requiring subgroups to be single-specialty since MVPs may be built around conditions rather than specialties, and this could discourage team-based care and disenfranchise clinician types whose primary specialty designation is related to their clinical degree and not to the specific kind of care they provide (such as PAs, NPs, hospitalists, etc.). For example, a multispecialty group could include a "stroke team" with neurologists, cardiologists, neurosurgeons, emergency physicians, neuroradiologists and NPs/PAs who might want to form a subgroup. CMS should provide group practices with the flexibility to decide the most clinically appropriate way to organize its clinicians into subgroups for purposes of MIPS value-based assessments. **Finally, we request that CMS consider the feasibility of allowing clinicians to also report via subgroups under traditional MIPS.** CMS is only proposing seven MVPs for 2023, which means that most clinicians will not yet have the opportunity to participate through this pathway.

Traditional MIPS

- **MIPS Performance Threshold.** Under the statute, CMS must compute a performance threshold to which the final scores of MIPS eligible clinicians are compared to determine the MIPS payment adjustment factors for a year. Under the law, the performance threshold for a year must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by CMS, starting with the 2022 performance year/2024 payment year. Final scores of MIPS eligible clinicians are compared to the MIPS performance threshold each year to determine MIPS payment adjustments. In this rule, CMS proposes to use the 2019 MIPS payment year as the prior period and the rounded mean final score of 75 points as the performance threshold for the 2022 performance year, which is consistent with CMS' annual performance threshold increase of 15 points for year two to five of the program.

Although we appreciate CMS selecting a performance threshold that represents the lowest possible value it could choose per the statute, we request that CMS consider ways that it can take advantage of other authorities — such as under the Extreme and Uncontrollable Circumstances Hardship exception policy or the COVID-19 Public Health Emergency (PHE) — to maintain the current performance threshold of 60 points in light of ongoing disruptions to the health care system. CMS estimates that the proportion of clinicians receiving a positive or neutral payment adjustment would decrease from 91.7% to 67.5% if the performance threshold were increased to this level. Subjecting so many MIPS eligible clinicians to potential MIPS penalties in the 2024 payment year would be insensitive to the impact of the PHE on medical practice and the substantial Medicare cuts that physicians face in the coming years. This proposal also ignores the significant investment practices must make to comply with MIPS. In a recent study, physicians from a sample of specialties, including general surgery, spent an average of $12,811 per physician on MIPS-related expenses in a year, including physician, health care professional, and administrative staff time, as well as IT and external vendor costs.[2] Physician practices also reported spending more than 200 hours per physician annually on MIPS-related activities, including tracking quality measures, attending training sessions, creating or implementing improvement activities and collecting data or entering information into the patient's electronic health record. Furthermore, with COVID-19 still surging, it is unrealistic and inappropriate to set a performance threshold for 2022 based on benchmarks evaluating care delivery in a pre-COVID world.

If CMS finalizes a higher MIPS performance threshold against our recommendation, then we request that it at least ensure that other MIPS scoring policies (e.g., high priority measure bonus points and scoring floors for measures with no benchmarks) account for the challenges that will result from an increased performance threshold, particularly during a PHE. These policies are discussed in more detail below.

- **MIPS Performance Category Weights.** Per the statute, for 2022, CMS also proposes to decrease the Quality category weight to 30% and increase the Cost category weight to 30%. Similar to the MIPS performance threshold, **the AANS and the CNS strongly urge CMS to consider ways to take advantage of authority under the Extreme and Uncontrollable Circumstances Hardship exception policy or the COVID-19 PHE to maintain the weights of these categories for 2022.** Given ongoing concerns with the Cost category measures and the impact that COVID-19-related disruptions have had on cost data over the past few years, **we recommend that CMS assign a weight of 15% to the Cost category, consistent with how it was weighted before the PHE in 2019. At a minimum, we would like it maintained at 20% for 2022.**

- **Quality Category Policies**

    + Scoring. The AANS and CNS echo comments submitted by the Alliance of Specialty Medicine regarding support for policies that better incentivize the development and use of specialty-specific measures, particularly as CMS prepares to transition to MVPs and subgroup reporting. **Our recommendations include:**

        - Instead of allocating zero points for measures with no benchmarks, as proposed, CMS should provide credit to clinicians who take the time to report on more focused measures and contribute to the building of performance benchmarks.

[2] Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum.* 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527.

- CMS should consider raising the proposed floor for reporting on new measures (e.g., from 5 points to a minimum of 7 points) or simply suppress such measures to account for a considerably higher performance threshold during the 2022 performance year).

- We oppose the agency's proposal to end the bonus points offered for reporting on additional outcome or high priority measures and using end-to-end electronic reporting of quality measures. CMS should maintain these bonus points to encourage further use of outcome measures and electronic reporting, both of which are still not widely used among clinicians. Keeping these bonus points would also help ensure that clinicians who invest in more robust reporting efforts have a better chance of crossing a potentially higher performance threshold for the 2022 performance/2024 payment year and avoid a penalty.

- In light of COVID-19, we also continue to request that CMS suspend topped out measure scoring caps for 2022. In general, we oppose policies that result in capped scoring or the elimination of topped-out measures, particularly due to concerns about the accuracy of these determinations. High performance on one reporting option should not automatically trigger its removal. CMS should instead consider performance across reporting options before proposing to remove a measure to ensure it's reflective of all clinical care.

- We request greater transparency from CMS regarding measure removal decisions due to inconsistencies in these decisions.

- Since specialty society measure development has slowed down considerably due to the PHE and strained resources, the AANS and the CNS request that CMS temporarily refrain from removing measures to ensure all specialties have a sufficient number of measures to report to avoid a penalty.

+ Data completeness. **The AANS and the CNS also echo the Alliance of Specialty Medicine's recommendations regarding the data completeness threshold, including**:

  - Opposition to the agency's proposal to increase the data completeness threshold from 70% to 80% in 2023, since seamless reporting across providers and settings is still a challenge, hospital-based specialists often do not have direct control over EHR and other data collection systems. No other CMS quality programs at the hospital or health plan level rely on sample sizes as high as MIPS.

  - Similar to benchmarking, we request that CMS consider setting different data completeness thresholds for different types of measures (e.g., patient-reported outcome measures).

+ Automatic calculation of outcome-based administrative claims quality measure. In this rule, CMS discusses its interest in relying more on the automatic calculation of administrative claims measures. **The AANS and CNS do not support the automatic calculation of administrative claims measures. If CMS insists on including administrative claims quality measures in MIPS, physicians should choose to elect being held accountable to an administrative claims measure. CMS also should use historical data to produce informational reports that physicians can use to determine whether a measure may be attributed to them**. Although administrative claims measures reduce reporting burden, they raise concerns regarding attribution, retrospective analysis, the inability to measure individual physicians (versus population-level accountability) and outcomes. Electronic clinical quality measures (eCQM) and QCDR measures provide for a much richer data source and address

many of the shortcomings of administrative claims measures, including the inability to move to capture clinically meaningful outcomes.

+ Promoting Interoperability category policies. CMS proposes to modify the Provide Patients Electronic Access to Their Health Information measure to require MIPS eligible clinicians to ensure that patient health information remains available to the patient to access indefinitely. MIPS eligible clinicians would be required to ensure this information remains available indefinitely (i.e., not merely for a defined period). The proposed requirement would apply beginning with the performance period in 2022 and would include all patient health information from encounters on or after January 1, 2016. The AANS and CNS have concerns with requiring patient health information with encounter start date of January 1, 2016, be made immediately available starting with the CY 2022 EHR reporting period. Many physicians and health systems have digitized old medical records using digital imaging or PDF-style formats, making it challenging to search for or protect specific information. As such, this proposal would require physicians to engage in a time-consuming and costly manual review and potential redaction of certain information before the release of these notes. **Instead, CMS should give physicians the flexibility to provide most of the information requested but still allow for health information management personnel or a physician's professional judgment to determine when it is impractical for certain information to be made available in a "timely" manner (e.g., no less than a 48-hour window for physicians to review the patient's request for health information to determine whether the release will require manual redaction or extraordinary technical effort to accommodate state or federal law).**

  CMS also proposes to add a new Safety Assurance Factors for EHR Resilience Guides (SAFER) Guides measure to the Protect Patient Health Information objective of the PI category, beginning with the 2022 performance period/2024 MIPS payment year. This series of nine user guides, which were last updated in 2016, support the ability of health care providers to conduct self-assessments to optimize the safety and safe use of EHRs. CMS proposes that a MIPS eligible clinician must attest to having conducted an annual self-assessment using the High Priority Practices Guide at any point during the calendar year in which the performance period occurs, with one "yes/no" attestation statement accounting for the complete self-assessment using the guide. This measure would be required, but it would not be scored (i.e., reporting "yes" or "no" would not affect the total number of points earned for the PI category). **Although there would not yet be a penalty associated with this attestation, the AANS and the CNS oppose adopting this measure. This measure is outside the scope of the PI category, which is to demonstrate "meaningful use of certified EHR technology" and seems to focus on requirements that should apply to health IT vendors, not individual physicians. While we support efforts to ensure EHR safety, these guides are dated, potentially no longer relevant, and would place a significant burden on physicians, particularly smaller practices, who must simultaneously comply with technology upgrades required in the coming year by the 21st Century Cures Act. Instead, we encourage CMS to consider adding the SAFER Guides as an option under the Improvement Activities category.**

Qualified Clinical Data Registries (QCDRs)

The AANS and the CNS refer CMS to comments submitted by the Physician Clinical Registry Coalition (PCRC), which we endorse in their entirety.

Utilization Data RFI

Under MACRA, beginning with 2016, the Secretary must integrate utilization data information on Physician Compare. CMS previously implemented a policy to start to include utilization data in a

downloadable format in late 2017 and finalized that the specific codes to be included would be determined via data analysis and reported at the eligible clinician level. However, CMS is concerned that these data are currently presented in a technical way that is not easily accessible or usable by patients. The agency believes there is a need to present these data in a more public and consumer-friendly way, such as on Care Compare's clinician and group profile pages. CMS seeks comment on the potential types of utilization data that could help Medicare patients and their caregivers make informed healthcare decisions, as well as on technical considerations for presenting a specific affiliation between clinicians and diagnoses and/or procedures.

The AANS and the CNS appreciate the agency's desire to provide patients with more complete information about clinicians for purposes of informed health care decision-making — including details on clinician experience in performing specific types of procedures and/or treating particular conditions. However, we are concerned about the accuracy of utilization data and the potential misinterpretation or misuse of such data. For example, patients may falsely assume that high utilization indicates high quality or high-value care. In fact, it may mean overutilization and inappropriate care versus lower utilization, which may reflect more appropriate adherence to evidence-based indications. The dataset also would not include any utilization for Medicare Advantage, Medicaid, Veteran Affairs or private payor beneficiaries. Therefore, it could often erroneously represent physicians as having no experience with procedures they regularly perform and no experience with conditions they regularly diagnose and treat. CMS also notes that it may wish to apply a minimum experience level, such as the number of times a clinician performed a particular procedure or treated a specific condition. However, many services and diagnoses are distributed over large groups of procedure codes or diagnostic codes, respectively. Therefore, even if an individual physician regularly performs a service, the tool may incorrectly list them as having no experience since no single code exceeded a minimum threshold.

We recognize that CMS is required by statute to make utilization data available to the public. Still, we do not believe that utilization data are intended or well understood by the average Medicare consumer, particularly given the challenges and limitations discussed above. **Accordingly, we recommend that CMS continue to limit the release of utilization data to a downloadable data file that can be used by stakeholders who have the capacity and resources to conduct more technical analyses**.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

Mandated by the Protecting Access to Medicare Act (PAMA) of 2014, CMS implemented the Appropriate Use Criteria (AUC) for advanced diagnostic imaging program in January 2020, but has not, to date, enforced the penalties for non-compliance due to ongoing operational challenges. Under this program, ordering professionals at outpatient sites must consult appropriate use criteria (AUC) for every advanced diagnostic imaging order using a federally approved clinical decision support mechanism (CDSM) before a radiologist can furnish a scan.

The AUC program's effective date has been delayed numerous times due to its administrative complexity. In 2020, CMS launched an educational and operations testing period for the program, during which it continued to pay claims whether or not they correctly included AUC consultation information. In 2020, in response to the COVID-19 PHE, the educational and operations testing period was extended through CY 2021, with the penalty phase set to start on January 1, 2022. In this rule, CMS proposes to begin the AUC payment penalty phase of the program on the later of January 1, 2023, or January 1 of the year after the year in which the PHE for COVID-19 ends.

While the AANS and the CNS appreciate CMS once again delaying the enforcement of penalties, we continue to view the program as duplicative and unnecessary and support legislative and regulatory efforts to delay implementing the mandatory AUC consultation. Our concerns include:

- The AUC Program was enacted seven years ago, before MACRA. In that time, CMS has adopted numerous programs that address appropriate use of imaging, including the Quality Payment

Program (QPP) and multiple alternative payment models (APMs) launched by the Center for Medicare and Medicaid Innovation (CMMI). These other initiatives make the AUC Program unnecessary or in need of re-thinking — particularly as CMS accelerates movement away from fee-for-service and towards bundled payment and other shared risk models;
- There are already multiple, significant demands being placed on claims forms due to the QPP and other initiatives;
- The law is financially advantageous to CDSM developers at the expense of clinicians who order advanced diagnostic imaging tests;
- Not all applicable AUC will be available for consultation by the ordering professional because CDSM vendors can "pick and choose" among qualified AUC;
- The program may ultimately be costlier to administer than the potential for savings and lacks a patient outcomes or quality component; and
- There is still inadequate clinical data underpinning CDSM development and the inability for current electronic systems to capture the clinical nuance of the patient (resulting in irrelevant, if not erroneous, CDSM results).

Furthermore, our members report experiencing pressure from their hospitals to comply with this program prematurely. Even when imaging AUC present in the form of automated pop-ups that ask a neurosurgeon to consider ordering a different study, like a CT instead of an MRI, these are geared more towards primary care, and yet they result in multiple, time-consuming clicks for our members simply to get the message to go away. Physicians should not be expected to make investments in administratively burdensome and costly activities, especially when physician practices and hospitals are experiencing staffing shortages and when the consultation of AUC could be incentivized through existing CMS quality programs.

CMS has admitted on multiple occasions that the program is plagued by operational issues and other limitations that it does not have solutions to, including the statutory requirement that CMS collect all necessary information via the claims form. CMS also has been very candid that Congress did not understand the complexity of this law when it handed it over to CMS. These ongoing challenges recently caught the attention of Congress, resulting in language in the House Labor, Health and Human Service, Education Appropriations Subcommittee report adopted in July. The report includes the following provision:

> ***Medicare Appropriate Use Criteria Program.***
> *The Committee is aware that the Protecting Access to Medicare Act established the Medicare Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging. While the Committee recognizes the value of encouraging physicians and other health care professionals to consult AUC and clinical guidelines to support medical decision making, more than seven years have passed since Congress created the AUC program, which has not advanced beyond educational and operations testing. The Committee requests a report within 180 days of enactment of this Act on implementation of this program, including challenges and successes. In this report, CMS shall consider existing quality improvement programs and relevant models authorized under Sec.1115A of the Social Security Act and their influence on encouraging appropriate use of advanced diagnostic imaging. The Committee directs CMS to consult with stakeholders, including medical professional societies and developers of AUC and clinical guidelines, when formulating its report.*

We are optimistic this report language will result in a long-overdue discussion that will lead to legislation that repeals or substantially revises the law. Such action would give CMS and physicians the flexibility to consult AUC in a form and manner that is practical, efficient and meaningful to them and their practices. We also hope CMS will be responsive to the report language and work expeditiously to engage with AUC stakeholder organizations in formulating its report to Congress.

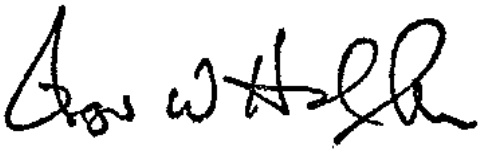
In the interim, **we request that CMS continue to delay this program while working with Congress to re-evaluate the feasibility and utility of the program and how AUC for imaging can be addressed through the QPP or other value-based initiatives.**

CONCLUSION

The AANS and the CNS appreciate the opportunity to provide feedback on these payment and quality provisions in the CY 2022 Medicare PFS proposed rule. We are particularly concerned about CMS's failure to incorporate the increased E/M office visit work into the 10- and 90-day global surgical codes, the failure to adopt the RUC-recommended values and ongoing problems with Medicare's Quality Payment Program. Furthermore, now is not the time for any cuts to the health care system, so we urge CMS to take all necessary steps to prevent any Medicare payment reductions.

Thank you for considering our comments. We appreciate the expertise, hard work and dedication of CMS leaders and staff, especially during the continuing COVID-19 public health emergency. We look forward to collaborating on these and other policy matters to ensure timely patient access to quality care.

Sincerely,



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Enclosure: RUC May 2021 Recommendations to CMS for CPT codes 22630, 22632, 22633, 22634, 630XX and 630X1

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AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Arthrodesis Decompression – Tab 4

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A CPT coding change application (CCA) was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for CPT codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, and revised definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment." In January 2021, the specialty societies surveyed the two new add-on codes and indicated that the revisions to existing codes were editorial precluding survey. The RUC disagreed and recommended that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX and 630X1) be surveyed together for review at the April 2021 RUC meeting and interim values were established for CPT codes 630XX and 630X1 until these two new codes could be reviewed again with the entire family in April.

22630 ***Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that maintaining the current work RVU of 22.09, which falls well below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components as supported by the survey: 40 minutes pre-service evaluation, 20 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 150 minutes intra-service time, and 30 minutes immediate post-service time, 1-99238 discharge visit, 1-99231 and 2-99232 post-operative visits and 2-99213 and 1-99214 office visits, 479 minutes total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as not to exceed survey median data. The positioning time was increased from the pre-time package to account for the additional work related to prone positioning.

The RUC noted that the total recommended time of 479 minutes is nearly identical to the total time of both the survey and the current code (487 minutes) which was initially valued in 1995. The post-operative visits have decreased by one, but the level of the visits has changed, practically resulting in a net change of zero in overall physician time despite the decrease of one visit. The RUC discussed the significant decrease in intra-service time of 30 minutes and considered crosswalk code alternatives; however, none of the crosswalk code options were deemed clinically comparable or sufficiently matched to the difficulty of the procedure. The change in time for the survey code, since it was valued in 1995, is attributed intra-operatively to the use of more effective drills, better X-rays, and several steps that streamline the procedure and make it more efficient. However, the RUC noted that while the procedure may be more efficient, it is not safer or less difficult. The elements that remain are

intense, such that the risk of the procedure, remains the same as it was originally; therefore, the RUC agreed that the current value should be maintained.

To justify the current work RVU of 22.09, the RUC compared the survey code to the top key reference service codes 22533 *Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar* (work RVU = 24.79, 180 minutes intra-service time and 549 minutes total time) and 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time and 482 minutes total time) and noted that the majority of respondents who chose 22533 as a key reference service indicated that the intensity/complexity of 22630 is similar to or somewhat more than 22533. Also, the respondents who chose 22612 as a key reference service indicated the intensity/complexity of 22630 is more than 22612.

The RUC also compared CPT code 22630 to MPC codes 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time and 404 minutes total time) and 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* (work RVU = 23.53, 150 minutes intra-service time and 502 minutes total time) and noted that the multi-specialty points of comparison code values appropriately bracket the survey code recommendation. For additional support, the RUC noted that the survey code is further bracketed by comparator codes 38720 *Cervical lymphadenectomy (complete)* (work RVU = 21.95, 150 minutes intra-service time and 482 minutes total time) and 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59, 150 minutes intra-service time and 480 minutes total time). The RUC concluded that the value of CPT code 22630 should be maintained at 22.09 work RVUs, which is below the 25th percentile of the survey. **The RUC recommends a work RVU of 22.09 for CPT code 22630.**

22632 ***Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that maintaining the current work RVU of 5.22, which falls well below the survey 25th percentile, appropriately accounts for the physician work involved in this add-on service. The RUC recommends 60 minutes of intra-service time and noted that the intraoperative time has not changed since the code was initially valued in 1995. At that time, the value of this code was calculated based on 25% of the base code.

The specialties noted that a comparison to the key reference service codes 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service time and 50 minutes total time) might support a higher work RVU, however, there was no compelling evidence that the work had changed. The RUC agreed that work had not changed.

The RUC also compared CPT code 22632 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and

noted that the comparator code has less intra-service and total time and is appropriately valued lower than the survey code. The specialties noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA) while, in comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same time and similar intensity: 11008 *Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)* (work RVU = 5.00, 60 minutes intra-service and total time) and 22854 *Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)* (work RVU = 5.50, 60 minutes intra-service and total time). The RUC concluded that the value of CPT code 22632 should be maintained at 5.22 work RVUs which is below the 25th percentile of the survey. **The RUC recommends a work RVU of 5.22 for CPT code 22632.**

22633 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and concurred that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that changes in intra-service and total time for the procedure warranted a direct work RVU crosswalk to MPC code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU= 26.80, 180 minutes intra-service and 442 minutes total time) which falls below the survey 25th percentile and has identical intra-service time that appropriately accounts for the total physician work involved in this service.

The RUC recommends the following physician time components as supported by the survey: 40 minutes pre-service evaluation, 20 minutes pre-service positioning, 15 minutes pre-service scrub/dress/wait time, 180 minutes intra-service time, and 30 minutes immediate post-service time, 1-99238 discharge visit, 1-99231 and 2-99232 post-operative visits and 2-99213 and 1-99214 office visits, 509 minutes total time. The scrub/dress/wait time was reduced from Pre-time Package 4 so as not to exceed survey median data. The positioning time was increased from the pre-time package to account for the additional work related to prone positioning. The RUC used a crosswalk due to the changes in visits that caused a decrease in total time, primarily due to a change in inpatient care. Previously, there were two level-3 hospital visits and one level-2 hospital visit, this has been decreased to two level-2 and one level-1 inpatient visit along with a discharge day visit causing a substantial decrease in total time for the procedure, greater than the decrease in intra-service time; thus, a crosswalk was selected rather than recommending maintaining current value. The RUC discussed the recommended crosswalk code 55866 and noted that it is recently reviewed and performed 20,000/year and places the intraoperative intensity appropriately within this family of codes.

To justify the crosswalk value of 26.80 work RVUs, the RUC compared the survey code to the top key reference service code 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes

intra-service time and 482 minutes total time) and 2nd key reference code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar* (work RVU = 27.13, 180 minutes intra-service time and 550 minutes total time) and noted that the physician work and total time of the survey code is appropriately bracketed between the two reference services using magnitude estimation.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same intraoperative time and similar intensity: 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh (complete)* (work RVU = 26.60, 180 minutes intra-service time and 424 minutes total time). The RUC concluded that, given changes in intra-service and total time for the procedure, CPT code 22633 should be valued based on a direct work RVU crosswalk to CPT code 55866 which falls below the survey 25th percentile and preserves rank order within the family. **The RUC recommends a work RVU of 26.80 for CPT code 22633.**

22634 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 7.96 appropriately accounts for the physician work involved in this add-on service and is less than the current value. The RUC noted that the current value for 22634 is based on a calculation in 2011 that estimated the new add-on code was 70% of the survey 25th percentile work RVU. Although the current survey median work RVU would suggest an increase is warranted, the specialty did not present compelling evidence for an increase and the RUC recommends a decrease in the work RVU to account for the five minute decrease in median intra-service time. The RUC recommends 65 minutes of intra-service time as supported by the survey. The RUC noted that this service is more difficult and complex than CPT code 22632 due to the more complex patient undergoing this procedure and considerable additional steps that are not included in 22630 and 22632.

To justify a work RVU of 7.96, the RUC compared the survey code to the top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that the survey code has greater intra-service and total time and involves more physician work than the reference service. It was also rated as more intense/complex overall than the key reference service by 88% of survey respondents who selected the KRS. The RUC also compared CPT code 22634 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code has much less intra-service and total time and is appropriately valued lower than the survey code.

For additional support, the RUC noted that the survey code is bracketed by comparator codes 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 7.00, 60 minutes intra-service and total time) and 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone*

angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure) (work RVU = 8.00, 60 minutes intra-service and total time). The RUC concluded that CPT code 22634 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes. **The RUC recommends a work RVU of 7.96 for CPT code 22634.**

630XX *Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)*

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic surgeons and spine surgeons and determined that the survey 25th percentile work RVU of 5.70 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 45 minutes intra-service time and noted that the time has increased by five minutes compared to the previous survey and that the recommendation is slightly higher than the interim recommendation. This code was initially surveyed in January of 2021. At that time, the RUC concluded that the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. The RUC was concerned that without the base codes and add-on codes being surveyed together, that the survey for the add-on codes may have included work from the primary codes. For this reason, an interim value was assigned with guidance to the specialties to perform a new survey to include the add-on codes and the base codes. The current survey included all six codes on one survey instrument. Additionally, the overall experience of the survey respondents is greater for the new survey of six codes when compared to the prior survey of only the new add-on codes. The RUC determined that the value of 5.70 is more accurate as it is based on the survey of the entire code family and further noted that compelling evidence is not necessary for increases over interim values since interim values are, by definition, temporary. The RUC also noted that the time included in this add-on service is essentially all high-risk. The lower intensity surgical exposure activities have already been completed with the base code, so the physician work of 630XX involves is the actual higher intensity decompression as clarified by CPT.

To justify a work RVU of 5.70, the RUC compared the survey code to the top key reference service code 22840 *Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)* (work RVU = 12.52, 60 minutes intra-service and total time) and noted that the reference code has both more physician work and intra-service time and is therefore valued higher.

The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work, time, and intensity of 630XX is greater than 34812.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the same intraoperative time and similar intensity: 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service time and 50 minutes total time) and code 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes intra-service and total time). The RUC concluded that CPT code 630XX should be valued at the 25th percentile work RVU as supported by the survey and comparator codes using magnitude estimation. **The RUC recommends a work RVU of 5.70 for CPT code 630XX.**

630X1 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 111 neurosurgeons, orthopaedic and spine surgeons and determined that the survey 25th percentile work RVU of 5.00 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 40 minutes intra-service time and noted that the time has increased by ten minutes compared to the previous survey. This code was initially surveyed in January of 2021. At that time, the RUC concluded that the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. For this reason, an interim value was assigned with guidance to the specialties to perform a new survey to include the add-on codes and the base codes. The new survey, which included all six codes, elicited a time that is only five minutes less than the work related to 630XX and is believed to be a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and of an additional segment. The RUC determined that the new value is more accurate as it is based on the survey of the entire code family and further noted that compelling evidence is not necessary for increases over interim values since interim values are, by definition, temporary.

To justify a work RVU of 5.00, the RUC compared the survey code to the top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that the codes have the same intra-service time, but the reference code is more intense and is appropriately valued higher than the survey code using magnitude estimate. The RUC also compared the survey code to the second key reference service code 22840 *Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)* (work RVU = 12.52, 60 minutes intra-service and total time) and noted that this reference code has more physician work and intra-service time and is therefore valued higher than the survey code.

The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time for 630X1 includes bony and soft tissue resection

(typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work and intensity of 630X1 is appropriately greater than 34812.

For additional support, the RUC noted that the survey code is appropriately bracketed by comparator codes with the similar intraoperative time and similar intensity: 44128 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU = 4.44, 40 minutes intra-service and total time) and 22585 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.52, 45 minutes intra-service and total time). The RUC concluded that CPT code 630X1 should be valued at the 25th percentile work RVU as supported by the survey and comparator codes using magnitude estimation. **The RUC recommends a work RVU of 5.00 for CPT code 630X1.**

Practice Expense
The Practice Expense Subcommittee removed the EQ168 *light, exam* for CPT codes 22630 and 22633. No direct practice expense inputs were recommended for the facility-only add-on codes 22632, 22634, 630XX and 630X1. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Arthrodesis **Posterior, Posterolateral or Lateral Transverse Process Technique** *To report instrumentation procedures, see 22840-22855, 22859. (Report in addition to code[s] for the definitive procedure[s].) Do not append modifier 62 to spinal instrumentation codes 22840-22848, 22850, 22852, 22853, 22854, 22859.* *To report bone graft procedures, see 20930-20938. (Report in addition to code[s] for the definitive procedure[s].) Do not append modifier 62 to bone graft codes 20900-20938.* **Corpectomy** identifies removal of a vertebral body during spinal surgery. **Facetectomy** is the excision of the facet joint between two vertebral bodies. There are two facet joints at each vertebral segment (see below) **Foraminotomy** is the excision of bone to widen the intervertebral foramen. The intervertebral foramen is bordered by the superior notch of the adjacent vertebra, the inferior notch of the vertebra, the facet joint and the intervertebral disc.				

Hemilaminectomy is removal of a portion of a vertebral lamina, usually performed for exploration of, access to, or decompression of the intraspinal contents.

Lamina pertains to the vertebral arch, the flattened posterior portion of the vertebral arch extending between the pedicles and the midline, forming the dorsal wall of the vertebral foramen, and from the midline junction of which the spinous process extends.

Laminectomy is excision of a vertebral lamina; commonly used to denote removal of the posterior arch.

Laminotomy is excision of a portion of the vertebral lamina, resulting in enlargement of the intervertebral foramen for the purpose of relieving pressure ~~in~~ on a spinal nerve root.

A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae. A vertebral interspace is the nonbony compartment between two adjacent vertebral bodies which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus, and two cartilaginous endplates.

Decompression performed on the same vertebral segment(s) and/or interspace[s] as posterior lumbar interbody fusion that includes laminectomy, facetectomy, and/or foraminotomy may be separately reported using 630XX, 630X1.

Decompression solely to prepare the interspace for fusion is not separately reported.

(e)22600	-	Arthrodesis, posterior or posterolateral technique, single ~~level~~ interspace; cervical below C2 segment	090	17.40 (No change)
(e)22610	-	thoracic (with lateral transverse technique, when performed)	090	17.28 (No change)
(e)22612	-	lumbar (with lateral transverse technique, when performed) (Do not report 22612 in conjunction with 22630 for the same interspace ~~and segment~~, use 22633)	090	23.53 (No change)
(e)+22614	-	each additional ~~vertebral segment~~ interspace (List separately in addition to code for primary procedure) (Use 22614 in conjunction with 22600, 22610, 22612, 22630 or 22633 when performed for arthrodesis at a different ~~level~~ interspace. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional ~~level~~ interspace, use 22614. When performing a posterior interbody fusion arthrodesis at an additional ~~level~~ interspace,	ZZZ	6.43 (No change)

		use 22632. When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional ~~level~~ interspace, use 22634) (For facet joint fusion, see 0219T-0222T) (For placement of a posterior intrafacet implant, see 0219T-0222T)		
(f)22630	J1	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar (Do not report 22630 in conjunction with 22612 for the same interspace and segment, use 22633)	090	22.09 (No change)
(f)+22632	J2	each additional interspace (List separately in addition to code for primary procedure) (Use 22632 in conjunction with 22612, 22630, or 22633 when performed at a different ~~level~~ interspace. When performing a posterior interbody fusion arthrodesis at an additional ~~level~~ interspace, use 22632. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional ~~level~~ interspace, use 22614. When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional ~~level~~ interspace, use 22634)	ZZZ	5.22 (No change)
▲22633	J3	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace ~~and segment~~; lumbar (Do not report with 22612 or 22630 ~~at the~~ for the same ~~level~~ interspace)	090	26.80
+▲22634	J4	each additional interspace and segment (List separately in addition to code for primary procedure) (Use 22634 in conjunction with 22633)	ZZZ	7.96

		(Do not report 22630, 22632, 22633, 22634 in conjunction with 63030, 63040, 63042, 63047, 63056, 630XX, 630X1, for laminectomy performed to prepare the interspace on the same spinal interspace[s]) (To report decompression performed on the same interspace as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 630XX, 630X1)		

Nervous System
Posterior Extradural Laminotomy or Laminectomy for Exploration/Decompression of Neural Elements or Excision of Herniated Intervertebral Discs

Definitions

For purposes of CPT coding . . .

63020 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical*

(For bilateral procedure, report 63020 with modifier 50)

63030 *1 interspace, lumbar*
(For bilateral procedure, report 63030 with modifier 50)

+63035 *each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)*

(Use 63035 in conjunction with 63020-63030)

(Do not report 63030, 63035 in conjunction with 22630, 22632, 22633, 22634 for laminotomy performed to prepare the interspace for fusion on the same spinal interspace)

(To report decompression performed on the same interspace and vertebral segment[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 630XX, 630X1)

(For bilateral procedure, report 63035 twice. Do not report modifier 50 in conjunction with 63035)

(For percutaneous endoscopic approach, see 0274T, 0275T)

63040 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical*

63042 *lumbar*

(For bilateral procedure, report 63042 with modifier 50)

+63043 *each additional cervical interspace (List separately in addition to code for primary procedure)*

(Use 63043 in conjunction with 63040)

(For bilateral procedure, report 63043 twice. Do not report modifier 50 in conjunction with 63043)

✚*63044* *each additional lumbar interspace (List separately in addition to code for primary procedure)*

(Use 63044 in conjunction with 63042)

(Do not report 63040, 63042, 63043, 63044, in conjunction with 22630, 22632, 22633, 22634 for laminotomy to prepare the interspace for fusion on the same interspace and vertebral segment[s])

(To report decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 630XX, 630X1)

(For bilateral procedure, report 63044 twice. Do not report modifier 50 in conjunction with 63044)

Decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, facetectomy, or foraminotomy may be separately reported using 630XX.

Codes 630XX, 630X1 may only be reported for decompression at the same anatomic site(s) when posterior interbody fusion (eg, 22630) requires decompression beyond preparation of the interspace(s) for fusion.

63045 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical*

63046 *thoracic*

63047 *lumbar*

✚▲63048 each additional vertebral segment, cervical, thoracic or lumbar (List separately in addition to code for primary procedure

(Use 63048 in conjunction with 63045-63047)

(Do not report 63047, 63048 in conjunction with 22630, 22632, 22633, 22634 for laminectomy performed to prepare the interspace for fusion on the same vertebral segments and/or interspace[s])

	(To report decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 630XX, 630X1)			
+●630XX	J5	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	ZZZ	5.70
+●630X1	J6	each additional segment (List separately in addition to code for primary procedure) (Use 630X1 in conjunction with 630XX) (Use 630XX, 630X1 in conjunction with 22630, 22632, 22633, 22634)	ZZZ	5.00

63050 *Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;*

63051 *with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)*

Transpedicular or Costovertebral Approach for Posterolateral Extradural Exploration/Decompression

63055 *Transpedicular approach with decompression of spinal cord, equine and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic*

63056 *lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)*

+63057 *each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure*

(Use 63057 in conjunction with 63055, 63056)

(Do not report 63056, 63057 for a herniated disc, in conjunction with 22630, 22632, 22633, 22634 for decompression-to prepare the interspace on the same interspace[s])

(To report decompression performed on the same interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 630XX, 630X1)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22630 Tracking Number J1 Original Specialty Recommended RVU: **22.09**
Presented Recommended RVU: **22.09**
Global Period: 090 Current Work RVU: **22.09** RUC Recommended RVU: **22.09**

CPT Descriptor: Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with a history of previous discectomy at L4-L5 presents with a spondylolisthesis and intractable back pain that improves with recumbency or back bracing. Non-operative treatments have failed to control his symptoms. Arthrodesis via a unilateral or bilateral approach of L4-L5 is performed using a posterior interbody technique. (Note: Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.)

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 99% , In the ASC 1%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 13% , Overnight stay-more than 24 hours 88%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Review preoperative laboratory workup. Write preoperative orders for perioperative medications. Review MRI and/or other spinal imaging studies. Review planned incisions and procedure. Update H&P, review current medications, review surgical procedure, postoperative recovery in and out of the hospital, and the expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with the anesthesiologist. Perform preoperative time out, confirming patient identity, surgical site, procedure, indicated intraoperative medications, and antibiotic and DVT prophylaxis, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuromonitoring electrodes. Following induction of anesthesia, assist with positioning of the patient prone. Verify and/or assist with padding of the patient to prevent pressure on neurovascular structures and placement of any traction devices to facilitate intraoperative imaging. Scrub and gown. Supervise preparing and draping of the patient. Perform surgical time out.

Description of Intra-Service Work: Following skin incision, dissection is carried out through the subcutaneous tissue and fascia to the posterior spinal elements. The subcutaneous and muscular tissues are reflected to expose the posterior surface of the lamina and over the facet(s) and/or transverse processes of the segment to be fused. Verification of the levels is confirmed with imaging. Bone cutting tools are used to remove as much of the lamina above and below the facets and to remove as much of the medial edges of the facets as is necessary for adequate exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device with graft) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. The neural elements are inspected to confirm that they are free of any impingement from the implants in the canal and neuroforamen. An interposition membrane, as by free fat graft, may be used to cover the exposed dura and nerve root. Muscles and fascia

are sutured. A drain is inserted through a separate stab wound and secured. The subcutaneous tissues and skin are closed. (Note: Decompression of neural elements, instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work:
Facility: Apply sterile dressings. Assist with repositioning patient supine. When anesthesia has been reversed, transfer the patient to the recovery room. Write an operative note in the patient's record. Monitor patient for abnormal neurological findings prior to discharge from recovery to the surgical floor. Sign the OR forms, including pre- and postoperative diagnosis and operations performed. Discuss procedure outcome with family. Dictate postoperative report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company. Order and review films to check the alignment of the lumbar spine. Later the same day, review nursing and other provider chart notes, assess patient neurovascular status and pain. Write orders or update orders, as necessary, for medications, diet, and patient activity. Chart patient progress notes. On subsequent days, examine the patient, check wounds and neurovascular status. Review nursing and other provider chart notes. Chart patient progress notes. Discuss (oral/written) patient progress with referring physician. Answer (oral/written) questions from patient and/or family, nursing and other staff, and insurance staff. When safe to discharge patient to home, conduct final exam, including neurovascular and pain status, write orders for follow-up visits, post-discharge laboratory tests, imaging, home care, and physical therapy. Order medications needed post-discharge. Discuss home restrictions and activity levels (ie, diet, bathing, driving, exercise) and follow-up planning with patient/family. Complete all appropriate medical records, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office: Examine patient and perform neurological exam and pain assessment. Write orders for medications. Order and review periodic imaging, as appropriate. Monitor wounds and remove sutures and staples when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer patient and/or family questions and insurance staff questions. Discuss (oral/written) patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22630					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**10.00**	33.00	300.00	
Survey RVW:	19.60	25.00	**25.52**	28.00	35.00	
Pre-Service Evaluation Time:			**48.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	120.00	**150.00**	180.00	270.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	22630	**Recommended Physician Work RVU: 22.09**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**150.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22533	090	24.79	**RUC Time**

CPT Descriptor Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22612	090	23.53	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35301	090	21.16	**RUC Time**	35,904

CPT Descriptor 1 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
32669	090	23.53	**RUC Time**	1,894

CPT Descriptor 2 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 30 **% of respondents:** 27.0 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 22630	Top Key Reference CPT Code: 22533	2nd Key Reference CPT Code: **22612**
Median Pre-Service Time	75.00	116.00	95.00
Median Intra-Service Time	150.00	180.00	150.00
Median Immediate Post-service Time	30.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	100.0	100.00	100.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	86.0	85.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**479.00**	**549.00**	**482.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	38%	43%	13%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	53%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	50%	43%
Physical effort required	3%	43%	53%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	47%	37%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	20%	52%	28%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	24%	76%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	20%	80%
Physical effort required	4%	24%	72%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	36%	64%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX , 630X1) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 630XX and 630X1 for CY 2022.

Recommendation – 22630

We recommend maintaining the current work RVU of 22.09. Although the intraoperative time decreased, the postoperative work increased and the total time is nearly identical.

Positioning time

Additional time was added to the package time of 3 minutes for supine positioning. These patients will typically be positioned prone.

Key Reference Code Comparison

KRS1: The respondents who chose 22533 as a reference indicated the intensity/complexity of 22630 is similar to somewhat more than 22533.

KRS2: The respondents who chose 22612 as a reference indicated the intensity/complexity of 22630 is more than 22612.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	0.078	479	75	150	254
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	24.79	0.076	549	116	180	253
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	23.53	0.088	482	95	150	237

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	21.16	0.104	404	75	120	209
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	0.078	479	75	150	254

32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	23.53	0.084	502	75	150	277

Other Code Comparison

Codes 38720 and 44140 bracket and offer further support of the recommended wRVU of 22.09 for 22630.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
38720	Cervical lymphadenectomy (complete)	21.95	0.075	482	75	150	257
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	0.078	479	75	150	254
44140	Colectomy, partial; with anastomosis	22.59	0.079	480	60	150	270

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22630

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,654
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 4100 Percentage 72.51 %

Specialty orthopaedic surgery Frequency 1554 Percentage 27.48 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22630

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22632 Tracking Number J2 Original Specialty Recommended RVU: **5.22**
Presented Recommended RVU: **5.22**
Global Period: ZZZ Current Work RVU: **5.22** RUC Recommended RVU: **5.22**

CPT Descriptor: Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with a history of previous discectomy and posterolateral fusion of L4-L5, presents with pseudarthrosis of L4-L5, progressive spondylolisthesis of L5-S1, minimal signs of nerve root dysfunction, and intractable back pain that improves with recumbency or back bracing. Non-operative treatments have failed to control his symptoms. During (separately reported) posterior lumbar interbody arthrodesis of L4-L5, he undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterior interbody technique. (Note: This is an add-on procedure. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the posterior interbody arthrodesis of the additional L5-S1 interspace.)

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Skin, muscle, and fascia incisions are extended to provide for enough retraction to safely expose the additional interspace. The ligamentum flavum and/or scar is removed from between the laminae of the additional interspace. The laminae and medial edges of the facets are removed with bone cutting instruments to a degree sufficient to allow safe exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. The neural elements are inspected to confirm that they are free of any impingement from the implant(s) in the canal and neuroforamen. An interposition membrane, as by fat graft, is applied over the exposed dura and nerve roots of the additional space. (Note: Decompression of neural elements, instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22632					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**5.00**	20.00	300.00	
Survey RVW:	3.00	6.23	**7.48**	9.44	34.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	22.00	45.00	**60.00**	60.00	240.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22632	**Recommended Physician Work RVU: 5.22**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22552	ZZZ	6.50	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 23.4 **%**

Number of respondents who choose 2nd Key Reference Code: 23 **% of respondents:** 20.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 22632	Top Key Reference CPT Code: 22614	2nd Key Reference CPT Code: **22552**
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	60.00	40.00	45.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**40.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	27%	50%	23%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	31%	69%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	35%	65%
Physical effort required	8%	31%	62%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	42%	58%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	35%	57%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	39%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	48%	48%
Physical effort required	0%	30%	70%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	48%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar

interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX , 630X1) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 630XX and 630X1 for CY 2022.

Recommendation – 22632

The current value for 22632 is based on a calculation in 1995 that estimated the add-on code was 25% of the primary procedure for an additional interspace. Although the current survey would suggest an increase is warranted in comparison to other similar codes, we do not have compelling evidence for an increase. Therefore, we recommend maintaining the current work RVU of 5.22. Intraoperative time has not changed.

Key Reference Code Comparison

KRS1: The respondents who chose 22614 as a reference indicated the intensity/complexity of 22632 is more/much more than 22614.

KRS2: The respondents who chose 22552 as a reference indicated the intensity/complexity of 22632 is similar/more than 22552.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	5.22	0.087	60	0	60	0
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	6.50	0.142	50	5	45	0

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace	5.22	0.087	60	0	60	0

	(other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)						

Other Code Comparison

Codes 11008 and 22854 bracket and offer further support of the recommended wRVU of 5.22 for 22632.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	5.00	0.087	60	0	60	0
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	5.22	0.087	60	0	60	0
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	5.50	0.092	60	0	60	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22632

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,875
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 1300 Percentage 69.33 %

Specialty orthopaedic surgery Frequency 575 Percentage 30.66 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22632

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22633 Tracking Number J3 Original Specialty Recommended RVU: **26.80**
Presented Recommended RVU: **26.80**
Global Period: 090 Current Work RVU: **27.75** RUC Recommended RVU: **26.80**

CPT Descriptor: Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female presents with a degenerative spondylolisthesis of L4-L5 causing mechanical low back pain. Non-operative treatments have failed to control her symptoms. Via unilateral or bilateral approach to the L4-L5 interspace, arthrodesis is performed using a posterolateral technique with posterior interbody technique. (Note: Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported.)

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 7% , Overnight stay-more than 24 hours 93%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Review preoperative laboratory workup. Write preoperative orders for perioperative medications. Review MRI and/or other spinal imaging studies. Review planned incisions and procedure. Update H&P, review current medications, review surgical procedure, postoperative recovery in and out of the hospital, and the expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with the anesthesiologist. Perform preoperative time out, confirming patient identity, surgical site, procedure, indicated intraoperative medications, and antibiotic and DVT prophylaxis, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuromonitoring electrodes. Following induction of anesthesia, assist with positioning of the patient prone. Verify and/or assist with padding of the patient to prevent pressure on neurovascular structures and placement of any traction devices to facilitate intraoperative imaging. Scrub and gown. Supervise preparing and draping of the patient. Perform surgical time out.

Description of Intra-Service Work: Following skin incision, dissection is undertaken through the subcutaneous tissue and fascia to the posterior spinal elements. The subcutaneous and muscular tissues are reflected to expose the posterior surface of the lamina and out over the facet(s) and/or transverse processes of the segment to be fused. Verification of the levels is undertaken with imaging. Bone cutting tools are used to remove as much of the lamina above and below and as much of the medial edges of the facets as is necessary for adequate exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. Decortication of the posterolateral elements (transverse process, any remaining lamina, and/or facets) is undertaken, and graft material is packed posterolaterally to complete the arthrodesis preparations for the fusion. The neural elements are inspected to confirm that

they are free of any impingement from the implants in the canal and neuroforamen. An interposition membrane, as by free fat graft, may be used to cover the exposed dura and nerve root. Muscles and fascia are sutured. A drain is inserted through a separate stab wound and secured. The subcutaneous tissues and skin are closed. (Note: Decompression of neural elements, instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work:
Facility: Apply sterile dressings. Assist with repositioning patient supine. When anesthesia has been reversed, transfer the patient to the recovery room. Write an operative note in the patient's record. Monitor patient for abnormal neurological findings prior to discharge from recovery to the surgical floor. Sign the OR forms, including pre- and postoperative diagnosis and operations performed. Discuss procedure outcome with family. Dictate postoperative report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company. Order and review films to check the alignment of the cervical spine. Later the same day, review nursing and other provider chart notes, assess patient neurovascular status and pain. Write orders or update orders, as necessary, for medications, diet, and patient activity. Chart patient progress notes. On subsequent days, examine the patient, check wounds and neurovascular status. Review nursing and other provider chart notes. Chart patient progress notes. Discuss (oral/written) patient progress with referring physician. Answer (oral/written) questions from patient and/or family, nursing and other staff, and insurance staff. When safe to discharge patient to home, conduct final exam, including neurovascular and pain status, write orders for follow-up visits, post-discharge laboratory tests, imaging, home care, and physical therapy. Order medications needed post-discharge. Discuss home restrictions and activity levels (ie, diet, bathing, driving, exercise) with patient/family. Complete all appropriate medical records, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

Office: Examine patient and perform neurological exam and pain assessment. Write orders for medications. Order and review periodic imaging, as appropriate. Monitor wounds and remove sutures and staples when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer patient and/or family questions and insurance staff questions. Discuss (oral/written) patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22633					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	22.00	**40.00**	75.00	200.00	
Survey RVW:	19.00	28.00	**30.00**	32.00	48.24	
Pre-Service Evaluation Time:			**48.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	150.00	**180.00**	210.00	300.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**				
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	22633	**Recommended Physician Work RVU: 26.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**180.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**100.00**	99231x **1.00** 99232x **2.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**86.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **1.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22612	090	23.53	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22857	090	27.13	**RUC Time**

CPT Descriptor Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
55866	090	26.80	**RUC Time**	20,334

CPT Descriptor 1 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33641	090	29.58	**RUC Time**	1,849

CPT Descriptor 2 Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 19.8 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 18.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 22633	Top Key Reference CPT Code: 22612	2nd Key Reference CPT Code: **22857**
Median Pre-Service Time	75.00	95.00	95.00
Median Intra-Service Time	180.00	150.00	180.00
Median Immediate Post-service Time	30.00	30.00	45.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	100.0	100.00	100.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	86.0	69.00	92.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**509.00**	**482.00**	**550.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	23%	41%	36%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	23%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	23%	77%
Physical effort required	0%	23%	77%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	36%	59%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	38%	52%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	38%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	38%	62%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	38%	52%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX , 630X1) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 630XX and 630X1 for CY 2022.

Recommendation – 22633

We recommend crosswalking the work RVU of 26.80 for MPC code 55866 to 22633 to account for the slight decrease in intraoperative and total time. This value is less than the 25th percentile.

Positioning time

Additional time was added to the package time of 3 minutes for supine positioning. These patients will typically be positioned prone.

Key Reference Code Comparison

KRS1: The respondents who chose 22612 as a reference indicated the intensity/complexity of 22633 is more than 22612.

KRS2: The respondents who chose 22857 as a reference indicated the intensity/complexity of 22633 is similar to somewhat more than 22857.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	23.53	0.088	482	95	150	237
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	26.80	0.091	509	75	180	254
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	27.13	0.086	550	95	180	275

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	26.80	0.104	442	68	180	194
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including	26.80	0.091	509	75	180	254

	laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar						
33641	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	29.58	0.094	562	95	164	303

Other Code Comparison

Codes 43281 and 33255 bracket and offer further support of the recommended wRVU of 26.80 for 22633.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	26.60	0.107	424	70	180	174
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	26.80	0.091	509	75	180	254
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	29.04	0.106	516	95	180	241

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22633

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
38,096 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 19800 Percentage 51.97 %

Specialty orthopaedic surgery Frequency 18286 Percentage 47.99 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22633

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22634 Tracking Number J4 Original Specialty Recommended RVU: **7.96**
Presented Recommended RVU: **7.96**
Global Period: ZZZ Current Work RVU: **8.16** RUC Recommended RVU: **7.96**

CPT Descriptor: Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female presents with severe disc degeneration with lateral listhesis of L4-L5 above a L5-S1 lytic or isthmic spondylolisthesis. She has significant low back pain that has not responded to non-operative treatment. During (separately reported) interbody arthrodesis of L4-L5, she undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterolateral technique with posterior interbody technique. (Note: This is an add-on service. Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the arthrodesis of the additional L5-S1 interspace.)

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Skin, muscle, and fascia incisions are extended to provide for enough retraction to safely expose the additional interspace. The ligamentum flavum and/or scar is removed from between the laminae of the additional interspace. The laminae and medial edges of the facets are removed with bone cutting instruments to a degree sufficient to allow safe exposure of the disc space. The nerve root is carefully mobilized from adhesions and/or peridural membrane. Epidural veins are cauterized and cut. The nerve root(s) and thecal sac are protected by packing and retraction. The annulus is incised, and an ample section of it is removed by sharp dissection. The nucleus is removed within the disc space with rongeurs and curettes. Bone cutting instruments are used to remove cartilaginous and subchondral end-plates of the vertebrae above and below the disc to be fused. The bone dissection is fashioned to accept the graft in a way that will provide for contact, maintenance of disc space height, and stability. The spacer (graft and/or device) is impacted into the recipient site. When appropriate, the entire exposure, bone preparation, and spacer insertion and impaction are repeated from the other side of the table. Decortication of the posterolateral elements (transverse process, any remaining lamina, and/or facets) is undertaken, and graft material is packed posterolaterally to complete the arthrodesis preparations for the fusion. The neural elements are inspected to confirm that they are free of any impingement from the implant(s) in the canal and neuroforamen. An interposition membrane, as by fat graft, is applied over the exposed dura and nerve roots of the additional space. (Note: Decompression of neural elements instrumentation, and/or bone preparation or harvesting, when performed, are separately reported.)

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	22634					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**25.00**	43.00	200.00	
Survey RVW:	3.50	7.96	**8.83**	10.00	36.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	24.00	48.00	**65.00**	80.00	220.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22634	**Recommended Physician Work RVU: 7.96**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**65.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 22.5 **%**

Number of respondents who choose 2nd Key Reference Code: 23 **% of respondents:** 20.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 22634	Top Key Reference CPT Code: 22614	2nd Key Reference CPT Code: **22840**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	65.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**65.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	12%	40%	44%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	20%	76%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	24%	72%
Physical effort required	4%	16%	80%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	32%	64%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	9%	22%	70%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	13%	83%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	17%	78%
Physical effort required	0%	9%	91%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	4%	87%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar

interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX , 630X1) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 630XX and 630X1 for CY 2022.

Recommendation – 22634

The current value for 22634 is based on a calculation in 2011 that estimated the new add-on code was 70% of the survey 25th percentile work RVU. Although the current survey median work RVU would suggest an increase is warranted, we do not have compelling evidence for an increase. We recommend the survey 25th percentile work RVU of 7.96 to account for the slight 5 minute decrease in median intraoperative time.

Key Reference Code Comparison

KRS1: The respondents who chose 22614 as a reference indicated the intensity/complexity of 22634 is more/much more than 22614.

KRS2: The respondents who chose 22840 as a reference indicated the intensity/complexity of 22634 is more than 22840.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	7.96	0.122	65	0	65	0
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
22634	Arthrodesis, combined posterior or posterolateral	7.96	0.122	65	0	65	0

	technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)						

Other Code Comparison

The codes below bracket and offer further support of the recommended wRVU of 7.96 for 22634.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	7.00	0.117	60	0	60	0
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	7.96	0.122	65	0	65	0
33746	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)	8.00	0.133	60	0	60	0
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	8.00	0.133	60	0	60	0
33884	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	8.20	0.137	60	0	60	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22634

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
14,338 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. RUC database

Specialty neurosurgery Frequency 7900 Percentage 55.09 %

Specialty orthopaedic surgery Frequency 6438 Percentage 44.90 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 22634

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:630XX Tracking Number J5 Original Specialty Recommended RVU: **5.70**
Presented Recommended RVU: **5.70**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **5.70**

CPT Descriptor: Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During (separately reported) posterior lumbar interbody arthrodesis for L4-5 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 63-year-old female with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 level, requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention. (Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s].)

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Following bony and soft tissue resection and exposure of the L4-5 disc space for the interbody access and preparation for interbody arthrodesis, attention is turned to the additional bone and nervous system work required for decompression beyond what is required to access the disc space for the interbody arthrodesis. Additional portions of the laminae at the L4 and L5 vertebral segments are removed with a drill or bone biting instruments, and the inferior and superior facets are resected. The neural foraminae are expanded with bone biting instruments. The ligamentum flavum is dissected off the dura and completely removed, decompressing and mobilizing the neural elements. The neural elements are confirmed to be mobilized and decompressed. The additional intraoperative work is documented in the medical record.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	630XX					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	29.00	**50.00**	100.00	400.00
Survey RVW:	3.20	5.70	**6.50**	9.83	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**45.00**	60.00	210.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	630XX	**Recommended Physician Work RVU: 5.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22208	ZZZ	9.66	**RUC Time**

CPT Descriptor Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 24.3 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 16.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 630XX	Top Key Reference CPT Code: 22840	2nd Key Reference CPT Code: **22208**
Median Pre-Service Time	0.00	22840.0	0.00
Median Intra-Service Time	45.00	60.00	120.00
Median Immediate Post-service Time	0.00	0.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**60.00**	**135.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	30%	33%	37%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	26%	74%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	26%	70%
Physical effort required	11%	26%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	22%	74%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	17%	22%	28%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	39%	11%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	28%	17%	56%
Physical effort required	22%	22%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	17%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar

interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX , 630X1) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 630XX and 630X1 for CY 2022.

Recommendation – 630XX

We recommend a work RVU of 5.70 (survey 25th percentile) and total time of 45 minutes. This RVW is higher than the interim recommendation of 5.55 which was the prior survey 25th percentile for a total time of 40 minutes.
Rationale: The RUC previously accepted the survey 25th percentile as interim, but believed the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. This new survey included all six codes. In addition, the overall experience of the survey respondents is greater for the new survey of 6 codes when compared to the prior survey of the add on codes (ie, although the median is still 50, there is a shift to the right).

Key Reference Code Comparison

KRS1: The respondents who chose 22840 as a reference indicated the intensity/complexity of 630XX is more/much more than 22840.

KRS2: The respondents who chose 22208 as a reference indicated the intensity/complexity of 630XX is overall similar to 22208.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0
630XX	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.70	0.127	45	0	45	0
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	9.66	0.78	135	0	120	15

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST

34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
630XX	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.70	0.127	45	0	45	0

Other Code Comparison

Codes 22585 and 22552 bracket and offer further support of the recommended wRVU of 5.70 for 630XX.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	5.52	0.123	45	0	45	0
630XX	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.70	0.127	45	0	45	0
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	6.50	0.142	50	5	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There has been no reporting mechanism for this work since 2015. Please see supplemental file with an historical reporting overview.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
11,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 5830 Percentage 53.00 %

Specialty orthopaedic surgery Frequency 5170 Percentage 47.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63066

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:630X1 Tracking Number J6 Original Specialty Recommended RVU: **5.00**
Presented Recommended RVU: **5.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **5.00**

CPT Descriptor: Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During (separately reported) posterior lumbar interbody arthrodesis for L4-5 and L5-S1 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 68-year-old male with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 and L5-S1 levels requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention at each level. The first segment laminectomy has been completed (separately reported) and now the additional segment is addressed. (Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s] of the additional segment.)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: After (separately reported) bony and soft tissue resection and exposure of the L4-L5 and L5-S1 disc spaces for the interbody access and preparation for arthrodesis is completed, along with the (separately reported) decompression of neural elements at the L4-L5 interspace, attention is turned to the additional bone and nervous system work required for decompression of the L5-S1 interspace beyond what is required to access the disc space for the interbody arthrodesis. Additional portions of the laminae at the L5 and S1 vertebral segments are removed with the drill or bone biting instruments, and the inferior and superior facets are resected. The neural foraminae are expanded with bone biting instruments. The ligamentum flavum is dissected off the dura and completely removed, allowing for decompression and mobilization of the neural elements are mobilized. The neural elements are confirmed to be mobilized and decompressed. The additional intraoperative work is documented in the medical record.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	630X1					
Sample Size:	2028	**Resp N:**	111			
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**30.00**	70.00	400.00
Survey RVW:	3.00	5.00	**6.00**	7.38	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	30.00	**40.00**	45.00	210.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	630X1	**Recommended Physician Work RVU: 5.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 17.1 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 17.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 630X1	Top Key Reference CPT Code: 22614	2nd Key Reference CPT Code: **22840**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	40.00	40.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**40.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	21%	63%	16%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	32%	68%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	26%	74%
Physical effort required	0%	37%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	26%	74%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	32%	58%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	16%	84%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	16%	79%
Physical effort required	11%	21%	68%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	16%	79%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar

interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (630XX and 630X1) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, there would be assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 630XX , 630X1) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 630XX and 630X1 for CY 2022.

Recommendation – 630X1

We recommend a work RVU of 5.00 (survey 25th percentile) and total time of 40 minutes. This RVW is higher than the interim recommendation of 4.44 which was crosswalked to code 33572 with total time = 30 minutes).
Rationale: The RUC previously crosswalked a value that was less than the survey 25th percentile based on total time as interim, but believed the survey was flawed because the add-on codes were not surveyed in conjunction with the base codes. This new survey included all six codes. In addition, the overall experience of the survey respondents is greater for the new survey of 6 codes when compared to the prior survey of the add on codes (ie, the 25th pctl, median, 75th pctl, and max 12-month experience is all greater). The new survey, which included all codes, elicited a time that is only 5 minutes less than the work related to 630XX and that we believe is a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and of an additional segment.

Key Reference Code Comparison

KRS1: The respondents who chose 22614 as a reference indicated the intensity/complexity of 630X1 is more than 22614.

KRS2: The respondents who chose 22840 as a reference indicated the intensity/complexity of 630X1 is more/much more than 22840.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0
630X1	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	5.00	0.125	40	0	40	0
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0

MPC Code Comparison

There are few MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported percutaneous delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, the lower intensity exposure and closure for the survey code are performed as part of the primary arthrodesis code.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
630X1	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	5.00	0.125	40	0	40	0

Other Code Comparison

Codes 44128 and 22585 bracket and offer further support of the recommended wRVU of 5.00 for 630X1.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	4.44	0.106	40	0	40	0
630X1	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	5.00	0.125	40	0	40	0
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	5.52	0.123	45	0	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There has been no reporting mechanism for this work since 2015. Please see supplemental file with an historical reporting overview.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 2120 Percentage 53.00 %

Specialty orthopaedic surgery Frequency 1880 Percentage 47.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63066

+630XX and +630X1: Historical Reporting Overview

Coding History

In the 1990's, the work for arthrodesis and decompression was typically performed jointly by an orthopedic surgeon who would perform the arthrodesis and a neurosurgeon who would perform the decompression. Perhaps the single most important aspect of this coding was that the decompression and arthrodesis was being coded at the same spinal level. The codes were surveyed in that manner, and wRVUs were based on each surgeon's work.

In 1998, an AMA CPT workgroup that convened to discuss reporting correct coding for spine procedures via an anterior approach, also reviewed the lumbar interbody fusion code (22630) and decompression code (63047) and determined that each code may be separately and discretely performed and that there was no overlap in intra-service work. The workgroup also agreed that each code was valued based on the specific work of each code (ie, interbody fusion versus decompression). For CPT 2000, the CPT Panel introduced language into code 22630 which made this point clear: “minimal laminectomy and/or discectomy to prepare the interspace.” The spirit of that language continues to this day in the parenthetical “other than for decompression.” That particular position was reinforced in the January 2001 *CPT Assistant* where a case illustration of a patient requiring a decompression and an interbody fusion was presented and the statement made, “63047-51 should be reported in addition to the code 22630.”

In 2012, in recognition that posterolateral fusions were commonly performed along with interbody fusions, a new bundled code (22633) was established to include the work of interbody fusions (22630) and posterolateral fusions (22612) being bundled together into 22633. It is important to note that the decompression element of the operation (63047) remained a separate entity as intended by the initial valuation of that code and the inclusion of ("other than for decompression") in the code descriptor.

In 2014, confusion, both at education seminars and in print, about correct coding of the additional work of laminectomy persisted, with societies not agreeing on appropriate coding for the additional work of decompression performed concurrently with interbody fusion.

In January 2015, due to misinformed educational materials, CMS took a drastic departure from the application of the CPT codes that had been in place for decades; specifically, the evolution of the codes, the validated surveys for each of the separate codes, and valuation of separate work, by establishing NCCI edits: *"CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy…; lumbar) or 63047 (laminectomy…; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047."* [Chapter 4 of the NCCI manual]

In September 2015, the stakeholder societies conducted discussions with NCCI (CMS) about the history and valuation of codes 22630-22634. NCCI staff communicated that CMS had no intention to modify its position on these code pairs and instead recommended proposing an add-on code for use with arthrodesis codes that would describe additional decompression when performed.

Overview of CPT Assistant

After the coding changes for CPT 2000, the following CPT Assistant article was published that describes correct reporting of 22630 and 63047 for the same interspace.

January 2001 page 12
Coding Consultation
Musculoskeletal System, Surgery, 22554, 22630, 63001-63048, 63075-63078 (Q&A)

Question: The descriptors of codes 22554 and 22630 describe anterior (22554) or posterior (22630) interbody technique arthrodeses to include laminectomy, and/or diskectomy to prepare the interspace (other than for decompression). In what procedural circumstance would the 63001-63048 code(s) be reported in addition to code 22630? Similarly, in what procedural circumstance would code(s) 63075-63078 be reported in addition to code 22554?

AMA Comment
For both codes 22554 and 22630…

To report code 22554…

To report code 22630, *Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar*, in addition to code 63047-51, *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*, again additional procedure(s) must have been performed. For example, in spinal procedures performed on patients having lateral lumbar stenosis, the surgeon may need to perform additional work above and beyond that described by the PLIF, including facetectomy(ies) and/or foraminotomy(ies), to adequately decompress the nerve roots. For the purpose of this example, code 63047-51 should be reported in addition to code 22630.

Regarding the issue of laterality…

To further clarify, code 22630 may also require the additional performance of a posterior fusion, which involves bone grafting and placement of posterior instrumentation. These procedures should be additionally reported. If the surgeon uses a threaded bone dowel or prosthetic device in the disk space, then code +22851 should be reported. If any other type of bone graft is performed, the appropriate bone graft code should be reported.

The anterior fusion procedure described by code 22554…

In 2016, AMA CPTA staff drafted a FAQ based on the NCCI edit that was established. The stakeholder societies were not contacted about this FAQ. If we had been contacted, we would have informed AMA staff that we were in the process of discussions with CMS about coding misinformation.

October 2016 page 11
Frequently Asked Questions: Surgery: Nervous System

Question: The procedures described in code 63047 was performed for decompression, which was documented in the operative note. In addition, the procedure described in code 22633 was also performed at the same interspace. How should this be reported?

Answer: Codes 63047 and 22633 cannot be reported for the same interspace. However, it is appropriate to report codes 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar, and 22633, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should be appended to indicate that these are two distinct procedures.

The October 2016 FAQ added considerable coding confusion and after much effort by the stakeholder societies, including presentation of the historical information in this document, CPTA published a coding correction.

> **May 2018 page 9**
> **Coding Correction: Reporting Codes 22633 and 63047**
>
> In the Frequently Asked Questions (FAQ) section (page 11) of the October 2016 issue of CPT® Assistant, the Surgery: Nervous System answer incorrectly stated that codes 22633, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, and 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar, may not be reported for the same interspace. On further analysis of this issue, it was demonstrated that this recommendation was inconsistent with previously published CPT® Assistant advice, which is that codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should then be appended to indicate that these are two distinct procedures.
>
> This correction aligns the coding advice with historical precedent published prior to the incorrect revisions in advice given in the October 2016 FAQ.
>
> The following is the corrected coding advice:
>
> *Surgery: Nervous System*
> Question: The procedure described in code 63047 was performed for decompression, which was documented in the operative note. In addition, the procedure described in code 22633 was also performed at the same interspace. How should this be reported?
>
> Answer: Codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should then be appended to indicate that these are two distinct procedures.

We appreciate that CPT recognized and corrected an errant FAQ.

Summary

Since the establishment of the CCI edits in 2015, surgeons have not been allowed to report 63047 with 22630-22634 for the same interspace. **This document is meant to explain why the current utilization for decompression at the same interspace is "zero."**

The new add-on codes respond to CMS's direction (via NCCI correspondence) that recommends establishing an add-on code for use with arthrodesis codes that would describe additional decompression when performed.

In addition to creation of the add-on codes, numerous new definitions and two instructional guidelines specify when 630XX and 630X1 correctly apply:

> Decompression performed on the same vertebral segment(s) and/or interspace[s] as posterior lumbar interbody fusion that includes laminectomy, facetectomy, and/or foraminotomy may be separately reported using 630XX, 630X1.
>
> Decompression solely to prepare the interspace for fusion is not separately reported.

ISSUE: Arthrodesis Decompression

TAB: 4

	Review							RVW					Total	PRE			INTRA				IMMD	POST Facility			POST-Office	12 Month Svy Experience				
SOURCE	Year	CPT	DESC	Glob	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	38	15 14 13 12 11	MIN	25th	MED	75th	MAX
REF1	2003	22533	Arthrodesis, lateral extracavitary technique, incluc	90	30	0.076	0.045			24.79			549	58	28	30			180			30	1	3	1.0	3 1					
REF2	2005	22612	Arthrodesis, posterior or posterolateral technique,	90	25	0.088	0.049			23.53			482	60	20	15			150			30	2	1	1.0	3					
Current	1995	22630	Arthrodesis, posterior interbody technique, includ	90		0.067	0.045			22.09			487	85					180			32		3	1.0	4					
SVY	2021	22630	Arthrodesis, posterior interbody technique, includ	90	111	0.100	0.052	19.60	25.00	25.52	28.00	35.00	487	48	20	15	60	120	150	180	270	30	2	1	1.0	1 2	0	5	10	33	300
REC		22630	maintain RVW	90		0.078	0.046			22.09			479	40	20	15			150			30	2	1	1.0	1 2					
REF1	1995	22614	Arthrodesis, posterior or posterolateral technique,	ZZZ	26	0.161	0.161			6.43			40						40												
REF2	2010	22552	Arthrodesis, anterior interbody, including disc spa	ZZZ	23	0.142	0.130			6.50			50	5					45												
Current	1995	22632	Arthrodesis, posterior interbody technique, includ	ZZZ		0.087	0.087			5.22			60						60												
SVY	2021	22632	Arthrodesis, posterior interbody technique, includ	ZZZ	111	0.125	0.125	3.00	6.23	7.48	9.44	34.00	60				22	45	60	60	240						0	1	5	20	300
REC		22632	maintain RVW	ZZZ		0.087	0.087			5.22			60						60												
REF1	2005	22612	Arthrodesis, posterior or posterolateral technique,	90	22	0.088	0.049			23.53			482	60	20	15			150			30	2	1	1.0	3					
REF2	2006	22857	Total disc arthroplasty (artificial disc), anterior app	90	21	0.086	0.049			27.13			550	60	20	15			180			45	2	1	1.0	4					
Current	2011	22633	Arthrodesis, combined posterior or posterolateral	90		0.080	0.049			27.75			565	40	18	20			200			30	2	1	1.0	3					
SVY	2021	22633	Arthrodesis, combined posterior or posterolateral	90	111	0.108	0.058	19.00	28.00	30.00	32.00	48.24	517	48	20	15	60	150	180	210	300	30	2	1	1.0	1 2	0	22	40	75	200
REC		22633	crosswalk RVW to MPC code 55866	90		0.091	0.053			26.80			509	40	20	15			180			30	2	1	1.0	1 2					
MPC	*2015*	*55866*	***Laparoscopy, surgical prostatectomy, retropubic***	*90*		*0.104*	*0.061*			*26.80*			*442*	*33*	*20*	*15*			*180*			*30*	*1*		*1.0*	*1 2*					
REF1	1995	22614	Arthrodesis, posterior or posterolateral technique,	ZZZ	25	0.161	0.161			6.43			40						40												
REF2	2005	22840	Posterior non-segmental instrumentation (eg, Harr	ZZZ	23	0.209	0.209			12.52			60						60												
Current	2011	22634	Arthrodesis, combined posterior or posterolateral	ZZZ		0.117	0.117			8.16			70						70												
SVY		22634	Arthrodesis, combined posterior or posterolateral	ZZZ	111	0.136	0.136	3.50	7.96	8.83	10.00	36.00	65				24	48	65	80	220						0	10	25	43	200
REC		22634	25th percentile	ZZZ		0.122	0.122			7.96			65						65												
REF1	2005	22840	Posterior non-segmental instrumentation (eg, Harr	ZZZ	27	0.209	0.209			12.52			60						60												
REF2	2007	22208	Osteotomy of spine, posterior or posterolateral ap	ZZZ	18	0.078	0.072			9.66			135						120			15									
SVY	2020	630XX	Laminectomy, facetectomy, or foraminotomy (unila	ZZZ	141	0.213	0.213	3.50	5.55	8.50	12.75	28.00	40				10	21	40	50	365						0	25	50	80	400
interim	2020	630XX	Laminectomy, facetectomy, or foraminotomy (unila	ZZZ		0.139	0.139			5.55			40						40												
SVY	2021	630XX	Laminectomy, facetectomy, or foraminotomy (unila	ZZZ	111	0.144	0.144	3.20	5.70	6.50	9.83	25.00	45				15	30	45	60	210						0	29	50	100	400
REC		630XX	25th percentile	ZZZ		0.127	0.127			5.70			45						45												
REF1	1995	22614	Arthrodesis, posterior or posterolateral technique,	ZZZ	19	0.161	0.161			6.43			40						40												
REF2	2005	22840	Posterior non-segmental instrumentation (eg, Harr	ZZZ	19	0.209	0.209			12.52			60						60												
SVY	2020	630X1	Laminectomy, facetectomy, or foraminotomy (unila	ZZZ	141	0.217	0.217	3.00	4.70	6.50	9.50	28.00	30				8	20	30	45	370						0	8	25	54	350
interim	2020	630X1	Laminectomy, facetectomy, or foraminotomy (unila	ZZZ		0.148	0.148			4.44			30						30												
SVY	2021	630X1	Laminectomy, facetectomy, or foraminotomy (unila	ZZZ	111	0.150	0.150	3.00	5.00	6.00	7.38	25.00	40				15	30	40	45	210						0	15	30	70	400
REC		630X1	25th percentile	ZZZ		0.125	0.125			5.00			40						40												

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 630XX, 630X1
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
PRESENTER(S): John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 04/2021

CPT Code	Long Descriptor	Global Period
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	090
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	ZZZ
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	090
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	ZZZ
630XX	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	ZZZ
630X1	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
22630	A 48-year-old male with a history of previous discectomy at L4-L5 presents with a spondylolisthesis and intractable back pain that improves with recumbency or back bracing. Non-operative treatments have failed to control his symptoms. Arthrodesis via a unilateral or bilateral approach of L4-L5 is performed using a posterior interbody technique. (Note: Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported.)
22633	A 68-year-old female presents with a degenerative spondylolisthesis of L4-L5 causing mechanical low back pain. Non-operative treatments have failed to control her symptoms. Via unilateral or bilateral approach to the L4-L5 interspace, arthrodesis is performed using a posterolateral technique with posterior interbody technique. (Note: Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported.)
22632	A 70-year-old male with a history of previous diskectomy and posterolateral fusion of L4-L5, presents with pseudarthrosis of L4-L5, progressive spondylolisthesis of L5-S1, minimal signs of nerve root dysfunction, and intractable back pain that improves with recumbency or

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 630XX, 630X1
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
PRESENTER(S): John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

CPT Code	Vignette
	back bracing. Non-operative treatments have failed to control his symptoms. During (separately reported) posterior lumbar interbody arthrodesis of L4-L5, he undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterior interbody technique. (Note: This is an add-on procedure. Decompression, instrumentation and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the posterior interbody arthrodesis of the additional L5-S1 interspace.)
22634	A 68-year-old female presents with severe disc degeneration with lateral listhesis of L4-L5 above a L5-S1 lytic or isthmic spondylolisthesis. She has significant low back pain that has not responded to non-operative treatment. During (separately reported) interbody arthrodesis of L4-L5, she undergoes additional interspace arthrodesis of L5-S1 via a unilateral or bilateral approach using a posterolateral technique with posterior interbody technique. (**Note**: This is an add-on service. Decompression, instrumentation, and/or bone preparation or harvesting, when performed, is separately reported. Only consider the additional work related to the arthrodesis of the additional L5-S1 interspace.)
630XX	During (separately reported) posterior lumbar interbody arthrodesis for L4-5 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 63-year-old female with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 level, requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention. (**Note**: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s].)
630X1	During (separately reported) posterior lumbar interbody arthrodesis for L4-5 and L5-S1 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 68-year-old male with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 and L5-S1 levels requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention at each level. The first segment laminectomy has been completed (separately reported) and now the additional segment is addressed. (Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s] of the additional segment.)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   AANS, CNS, AAOS, NASS, ISASS Advisors reviewed the current PE details and adjusted as appropriate,

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for

the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Current codes were used as references

3. Is this code(s) typically reported with an E/M service?

no

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

n/a

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

For code 22630, an exam light has been added for one visit at which the surgical wounds will be assessed and drain and suture/staple removal will occur.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms	Staff reviews all forms with patient and family to ensure all relevant history and diagnostic information is included.
Coordinate pre-surgery services (including test results)	Staff coordinates collection and documentation of imaging/lab results, patient specific information and other relevant patient information for surgical procedure including conducting requisite pre-surgery assessment with anesthesiologist. Enter and record all clinical updates in EHR.
Schedule space and equipment in facility	Staff interacts with facility to schedule space, supplies, equipment, and review checklists.
Provide pre-service education/obtain consent	Staff reviews procedure, complication risk, process of recovery, and answers patient/family questions.
Complete pre-procedure phone calls and prescription	Staff reviews preoperative medication changes, reviews patient medical status and answers final pre-admission questions.

   b. Service period (includes pre, intra and post):

Prior to discharge, office clinical staff will assist with necessary post-discharge care coordination, such as: Responding to patient/family questions about home activity restrictions and care of drains. Confirmation of discharge antibiotics if needed, and pain medication. Coordination with other physicians and QHPs involved in the care of the patient for transfer of records. Transitioning discharge information to the surgeon's office medical record, including medication list, correspondence and imaging or lab results pending at discharge.

   c. Post-service period:

The clinical staff work includes the standard activities involved in any E/M visit including ensuring the appropriate

supplies are available in the room, ensuring imaging and lab reports are available, rooming the patient, gowning, reviewing current medications/allergies in EHR, obtaining vital signs, assisting with wound care, coordination of care, and cleaning of the room.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

yes, SA048 and SA053

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	
DESCRIPTION	**Code**	**Unit**	**Item**	**Unit**

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 630XX, 630X1
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
PRESENTER(S): John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

			Qty	price
pack, post-op incision care (suture & staple)	**SA053**	**pack**		**5.63**
kit, staple removal		kit	1	
kit, suture removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

n/a

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF 031 table, power – required for **all** postop office visits
EQ168 light, exam – required for **one** postop office visit

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

n/a

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

FACILITY DIRECT PE INPUTS

CPT CODE(S): 22630, 22632, 22633, 22634, 630XX, 630X1
SPECIALTY SOCIETY(IES): AANS, CNS, AAOS, NASS, ISASS
PRESENTER(S): John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**22630**		**22630**		**22**
3		***RUC Collaboration Website***				Arthrodesis, posterior		Arthrodesis, posterior		Arthro
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	interbody technique, including laminectomy and/or discectomy to prepare interspace		interbody technique, including laminectomy and/or discectomy to prepare interspace		combined poster technic posterior
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**90**	**90**	**90**	**90**	**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 103.27**	**$ -**	**$ 92.65**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**216**	**0**	**197**	**0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**60**	**0**	**60**	**0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**12**	**0**	**12**	**0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**144**	**0**	**125**	**0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 79.92**	**$ -**	**$ 72.89**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20	
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8	
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20	
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7	
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**	**12**	**n/a**	**12**	**n/a**
77		**End: Patient leaves office/facility**								
78		**POST-SERVICE PERIOD**								
79		**Start: Patient leaves office/facility**								
82		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
83		99211 16 minutes	16							
84		99212 27 minutes	27							
85		99213 36 minutes	36				4		2	
86		99214 53 minutes	53						1	
87		99215 63 minutes	63							
88	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**144.0**	**0.0**	**125.0**	**0.0**

	A	B	D	E	F	I	J	K	L	M
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**22630**		**22630**		**22**
3		***RUC Collaboration Website***				Arthrodesis, posterior		Arthrodesis, posterior		Arthro
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	interbody technique, including laminectomy and/or discectomy to prepare interspace		interbody technique, including laminectomy and/or discectomy to prepare interspace		combined poster technic posterior
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**90**	**90**	**90**	**90**	**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 103.27**	**$ -**	**$ 92.65**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**216**	**0**	**197**	**0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**60**	**0**	**60**	**0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**12**	**0**	**12**	**0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0**	**144**	**0**	**125**	**0**
96	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
97		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 21.07**	**$ -**	**$ 17.78**	**$ -**
98	SA048	pack, minimum multi-specialty visit	4.0507	pack			4		3	
99	SA052	pack, post-op incision care (staple)	4.864	pack			1			
100	SA053	pack, post-op incision care (suture & staple)	5.63	pack					1	
101										
103	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
104		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 2.28**	**$ -**	**$ 1.98**	**$ -**
105	EF031	table, power	5968.4775	Office Visits	0.015838707		144		125	
106	EF014	light, surgical	2064.7828	Office Visits	0.00459289					
107	EQ168	light, exam	1332.1952	Office Visits	0.003535282				0	

	A	B	N	O	P	Q	R	S	T	U	V
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2			**633**	**22633**		**22632**		**22634**		**630XX**	
3		***RUC Collaboration Website***	desis,	Arthrodesis,		Arthrodesis, posterior		Arthrodesis,		Laminectomy,	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**	osterior or olateral ue with interbody	combined posterior or posterolateral technique with posterior interbody		interbody technique, including laminectomy and/or discectomy to prepare interspace		combined posterior or posterolateral technique with posterior interbody		facetectomy, or foraminotomy (unilateral or bilateral with decompression	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**90**	**90**	**90**	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 86.59**	**$ -**	**$ 92.65**	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	**180**	**0**	**197**	0	0	0	0	0	0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60**	**0**	**60**	0	0	0	0	0	0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**12**	**0**	**12**	0	0	0	0	0	0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**108**	**0**	**125**	0	0	0	0	0	0
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 66.60**	**$ -**	**$ 72.89**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	5		5						
16	CA002	Coordinate pre-surgery services (including test results)	20		20						
17	CA003	Schedule space and equipment in facility	8		8						
18	CA004	Provide pre-service education/obtain consent	20		20						
19	CA005	Complete pre-procedure phone calls and prescription	7		7						
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
74	CA036	Discharge day management	**12**	**n/a**	**12**	**n/a**		**n/a**		**n/a**	
77		**End: Patient leaves office/facility**									
78		**POST-SERVICE PERIOD**									
79		**Start: Patient leaves office/facility**									
82		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
83		99211 16 minutes									
84		99212 27 minutes									
85		99213 36 minutes	3		2						
86		99214 53 minutes			1						
87		99215 63 minutes									
88	CA039	Post-operative visits (total time)	**108.0**	**0.0**	**125.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

	A	B	N	O	P	Q	R	S	T	U	V
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2			**633**	**22633**		**22632**		**22634**		**630XX**	
3		***RUC Collaboration Website***	desis,	Arthrodesis,		Arthrodesis, posterior		Arthrodesis,		Laminectomy,	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**	osterior or lateral ue with interbody	combined posterior or posterolateral technique with posterior interbody		interbody technique, including laminectomy and/or discectomy to prepare interspace		combined posterior or posterolateral technique with posterior interbody		facetectomy, or foraminotomy (unilateral or bilateral with decompression	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**90**	**90**	**90**	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 86.59**	**$ -**	**$ 92.65**	$ -	$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	**180**	**0**	**197**	0	0	0	0	0	0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60**	**0**	**60**	0	0	0	0	0	0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**12**	**0**	**12**	0	0	0	0	0	0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**108**	**0**	**125**	0	0	0	0	0	0
96	**Supply Code**	**MEDICAL SUPPLIES**									
97		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 17.78**	**$ -**	**$ 17.78**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
98	SA048	pack, minimum multi-specialty visit	3		3						
99	SA052	pack, post-op incision care (staple)									
100	SA053	pack, post-op incision care (suture & staple)	1		1						
101											
103	**Equipment Code**	**EQUIPMENT**									
104		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 2.21**	**$ -**	**$ 1.98**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
105	EF031	table, power	108		125						
106	EF014	light, surgical	108								
107	EQ168	light, exam			0						

	A	B	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**630X1**	
3		***RUC Collaboration Website***	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	ZZZ	ZZZ
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	0	0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	0	0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	0	0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	0	0
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**		
14		**Start: Following visit when decision for surgery/procedure made**		
15	CA001	Complete pre-service diagnostic and referral forms		
16	CA002	Coordinate pre-surgery services (including test results)		
17	CA003	Schedule space and equipment in facility		
18	CA004	Provide pre-service education/obtain consent		
19	CA005	Complete pre-procedure phone calls and prescription		
29		**End: When patient enters office/facility for surgery/procedure**		
30		**SERVICE PERIOD**		
31		**Start: When patient enters office/facility for surgery/procedure:**		
74	CA036	Discharge day management	**n/a**	
77		**End: Patient leaves office/facility**		
78		**POST-SERVICE PERIOD**		
79		**Start: Patient leaves office/facility**		
82		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**
83		99211 16 minutes		
84		99212 27 minutes		
85		99213 36 minutes		
86		99214 53 minutes		
87		99215 63 minutes		
88	CA039	Post-operative visits (total time)	**0.0**	**0.0**

	A	B	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**630X1**	
3		***RUC Collaboration Website***	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression	
4	**Clinical Activity Code**	**Meeting Date: 04/2021** **Revision Date (if applicable): April 7, 2021** **Tab: 4** **Specialty: AANS, CNS, AAOS, NASS, ISASS**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	ZZZ	ZZZ
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	0	0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	0	0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	0	0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	0	0
96	**Supply Code**	**MEDICAL SUPPLIES**		
97		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**
98	SA048	pack, minimum multi-specialty visit		
99	SA052	pack, post-op incision care (staple)		
100	SA053	pack, post-op incision care (suture & staple)		
101				
103	**Equipment Code**	**EQUIPMENT**		
104		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**
105	EF031	table, power		
106	EF014	light, surgical		
107	EQ168	light, exam		