61624/26 and You!
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INTRODUCTION
Neurointerventional (NI) specialists are likely aware that two seemingly innocuous five-digit numbers—61624 and 61626—have outsized importance in our professional lives as they represent ‘transcatheter or percutaneous permanent occlusion or embolization of intra- and extra-Central Nervous System’ in the Current Procedural Technology (CPT) coding structure. Recently, 61624/26 have been flagged for reconstitution and revaluation. The goal of this note is to familiarize NI practitioners with why this revaluation is occurring and describe a survey that NI specialists might be asked to participate in.

Selected history
Medicare was founded in 1965 with former president Harry Truman receiving the first card denoting his participation. In that year, the American Medical Association (AMA) identified the need for a common medical language and established the CPT system; the first CPT coding book was published in 1966 and focused on surgery. In 1970, the second edition was published and included the five-digit codes typical today. With the passage of the Health Insurance Portability and Accountability Act (HIPAA), CPT was expanded and in 2000 the Center for Medicare and Medicaid Services (CMS) formally incorporated the codes into Medicare claims processing. CPT is currently the national coding standard. 1

The Omnibus Budget Reconciliation Act of 1989 initiated the use of a payment system that ultimately led to the resource-based relative value scale (RBRVS). In 1992, the AMA convened the AMA/Specialty Society Relative Value Scale-Update Committee (RUC). Codes developed at CPT are reviewed and valued at the RUC. These recommended values are submitted to CMS which makes the final determination of a service’s value.

RUC governance requires there be a review of the entire scale every 5 years. After the third quinquennial review CMS suggested that such reviews be turned from sporadic to ongoing, and the Relativity Assessment Workgroup (RAW) was formed. Utilizing screens, the RAW looks for ‘potentially misvalued codes’ for example, increasing utilization, change in site of service, change in physician specialty reporting the code or CPT code valuing similar verifiable data trails, as was common with early ‘Harvard-valued’ codes.

A RAW determinant that comes up for interventionalists is the ‘Codes reported together’ screen. The premise is that when codes occur together in a single patient on the same day, there might be efficiencies that should be accounted for in determining overall relative value. This screen has expanded in importance and scope since its creation with filters being triggered with lower levels of concurrent utilization. 2 Given the pervasive and proper use of procedural codes alongside ‘supervision and interpretation’ (S&I) codes, i.e., they are codes reported together. While one could argue these codes were designed to be reported together, that occurrence suggests to the RAW and CMS they might be potentially misvalued.

Screens have consequences
When a code is labeled ‘potentially misvalued’, specialty societies that enjoy membership in the AMA House of Delegates can make recommendations to the RAW regarding next steps, that is, the ‘action plan’. Potential pathways include, but are not limited to: codes remain as is, a rank order anomaly. Assessing the relativity of value of a service compared with other services is an important step in the RUC valuation process. As such, the RUC will typically recommend other services that could be related to a service and revalued together with the updated code. The result is that a single code being picked up by a screen often results in dramatic consequences across a broader family. 3

Historic codes of interest to neurointerventionalists
In 2010, the procedural codes associated with carotid and cerebral angiography were caught on the codes performed together screen. The CPT Editorial Panel approved a new series of codes in 2012. The new bundled codes were sent back to the RUC with revaluation starting in 2013. A standard four-vessel angiogram previously valued at 18.22 RVUs is now 14.25 RVUs, a reduction of 22%. 4 In 2014, the CPT/RUC Joint Workgroup recommended that the S&I codes for vertebroplasty and kyphoplasty be bundled. In February of that year the CPT Editorial Panel replaced eight Category 1 codes (22520–22525, 72291-flouroscopic guidance, and 72292-CT guidance) with six new codes (22510–22515) that bundled injection and imaging guidance/interpretation. 5 Utilizing a single level flouro-guided lumbar kyphoplasty as an example, pre-2015 bundling with each service uniquely valued that procedure generated 9.85 RVUs. The 2023 MPFS indicated 7.99 RVUs for that bundled service indicating a drop in reimbursement of approximately 19%.

Thrombectomy for stroke may be the most familiar example to NI specialists. Secondary to the bundling of the embolization and thrombolysis codes within the peripheral circulation, the S&I codes were changed and affected their use in the intracranial circulation requiring new codes for intracranial thrombectomy and infusions. Associated NI societies successfully supported the formation of an isolated bundled code, that is, 61645. The development of 61645 should theoretically be much more efficient as almost all service ‘efficiencies’ it is not surprising that the remedy is bundling together of previously discreet codes.

The RUC and CMS understands that a screen might pick up a single code that emanates from a similar group and that the revaluation process could lead to irrational valuations where a harder service compensates less than an easier or less time-consuming one, that is, a rank order anomaly. Assessing the relativity of value of a service compared with other services is an important step in the RUC valuation process. As such, the RUC will typically recommend other services that could be related to be revalued together with the updated code. The result is that a single code being picked up by a screen often results in dramatic consequences across a broader family. 4
components were bundled together rather than via the historical component coding approach.9

Based on the survey data, 61645 was valued at approximately 17 RVUs by the RUC. CMS subsequently downgraded the payment to 15 RVUs. It appears that CMS applied a clear methodological error when downgrading the RUC-derived payment, and the related societies argued that CMS return the roughly two RVUs to a refinement panel, that is, an independent final appeal of sorts that would review public comments and hear testimony from practicing physicians. The professional work remained valued at 15 RVUs.

61624/26—the time has come

61624/26 were identified in the relativity screen for ‘codes reported together’ as typically they were coded with 75894 and 75898. Various societies including the American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), American Society of Neuroradiology (ASNR), American College of Radiology (ACR), and Society of Interventional Radiology (SIR) declared their interest. SNIS is actively contributing to the ongoing discussions via these societies. Figuring out which codes are in the family and those that will be bundled involves an interplay between those societies and CPT. Once the AMA CPT Editorial Panel has approved the code set, the codes will be sent to the RUC for valuation.

Involved societies develop clinical vignettes to describe the typical patients for a particular service. Societies send a survey with the vignettes to random members to obtain estimates of the time and complexity required in performing a procedure in the typical patient. Time and complexity data from the surveys are critical for determining a work RVU for any code in this relativistic system. Societal representatives use the survey data to submit recommendations to the RUC for physician work, practice expense, and professional liability insurance crosswalks.

As part of the survey, societies include a list of procedures that survey takers may be familiar with, some of which may have similar work to services being valued, that is, reference services. Survey respondents select the procedure that they believe to be most similar in time and work cognizant of the global period of the code(s) being surveyed versus the reference service. Using the vignette and global period, the respondent will then estimate how much time it takes to perform the procedure.10

When one considers an RVU value for a service, it is important to understand that multiple individual components are utilized much like building blocks. In terms of RVU development, ‘time’ has three distinct components. The pre-service period includes all services provided in the 24 hours before the procedure. The intra-procedural service includes ‘skin-to-skin’ physician work in performing the (in this case) embolization. The post-service period includes all physician services after completion of the procedure. Respondents might potentially find it helpful to think about the specific components of a unique service to best compare with the reference service.10

Professional work might be thought of as consisting of three distinct elements: (1) time; (2) the mental effort and judgment necessary to perform the procedure; and (3) technical skill. The type of psychological stress that impacts professional work RVUs is the pressure involved with the outcome is heavily dependent upon skill and judgement where an adverse outcome has serious consequences.10 Finally, all of this is compiled by the survey taker into an estimate of the work RVU where one considers the value as it relates to the reference procedure.

DISCUSSION

The RBRVS system benefits from providers who perform the procedures under study being asked to inform the process based on their real-life experience. Indeed, one of the first items reported at the RUC when a code family is being discussed is the quality of the survey. The original determinant of 17 RVUs for thrombectomy was aligned with the survey results.

We believe that 61624/26 will be surveyed in late 2023 for valuation by the RUC in 2024. Surveys will be sent to random members via email. The survey generally takes approximately 40 min to 1 hour to complete. If selected to complete the survey, please take the opportunity to inform this process. Read the instructions and enclosed material carefully. Set aside sufficient time. Volunteer peers will serve as both subject matter experts and RUC advisors. They will use the survey results to achieve appropriate valuation of your professional efforts. A recent analysis of the impact of revaluation of Evaluation and Management Services describes other elements of the CMS process.11

CONCLUSION

Neurointerventionists have historically relied on component coding to describe procedures at a granular level. Reporting codes together will explicitly occur in a system that relies on building block components to describe a complex service. Each of the component codes were valued as discrete entities for all the elements that were described above. 61624/26 have now been identified on a codes reported together screen. As a result, these codes are being bundled. The RUC survey is your opportunity to describe properly the professional work associated with these codes. Take that opportunity as seriously as the RUC and CMS do.

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