AMA/Specialty Society RVS Update Committee
The Renaissance Chicago Downtown Hotel, Chicago, IL
April 23-26, 2025

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in April 2025. Doctor Ezequiel Silva, III, called the meeting to order on Friday, April 25, 2025, at 9:00 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:
Ezequiel Silva III, MD
Amr Abouleish, MD
Jennifer Aloff, MD
Margie C. Andreae, MD
Amy Aronsky, DO
Gregory L. Barkley, MD
Luke Barré, MD
James Blankenship, MD
Robert Dale Blasier, MD
Audrey Chun, MD
Gregory DeMeo, DO
Jeffrey P. Edelstein, MD
Leisha Eiten, AuD
Alexandra Flamm, MD
Matthew J. Grierson, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
M. Douglas Leahy, MD
Scott Manaker, MD
Bradley Marple, MD
Anne Miller, MD
Gregory Nicola, MD
John Proctor, MD
Sanjay Samy, MD
Christopher Senkowski, MD
G. Edward Vates, MD
James Waldorf, MD
Thomas J. Weida, MD

RUC Alternates:
Anita Arnold, DO
Eileen Brewer, MD
Neal Cohen, MD
Daniel Duzan, MD
Patrick Godbey, MD
Martha Gray, MD
David Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kevin Kerber, MD
Kristopher Kimmell, MD
Thomas Kintanar, MD
Timothy Laing, MD
Jim Levett, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Lauren Nicola, MD
Noah Raizman, MD
James Shoemaker, MD
Clarice Sinn, DO
Michael Sutherland, MD
Timothy Swan, MD
Thomas Turk, MD
Korinne Van Keuren, DNP, MS, RN
Mark Villa, MD
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

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

- Doctor Silva stated the following principles related to conference etiquette:
  - The RUC process enjoys a high reputation due to the expertise, diligence and professionalism of all participants. We depend upon the respect and professional courtesy accorded to every participant.
  - All participants shall treat each other with respect and courtesy during this meeting and in all our interactions.

- Doctor Silva communicated the following guidelines related to confidentiality:
  - All attendees shall respect our confidentiality provisions indicated in the agreement to which you attested via the registration process.
  - Confidentiality requirements extend to both materials and discussions at this meeting.
  - Recording devices are prohibited (including AI for notetaking). However, this meeting is being recorded by the AMA.
  - The full confidentiality agreement can be found on the RUC Collaboration site (Structure and Functions).

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

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

- Doctor Silva welcomed the following Member of the CPT Editorial Panel:
  - Timothy Swan, MD – CPT Editorial Panel Member

- Doctor Silva acknowledged the Centers for Medicare & Medicaid Services (CMS) Medical Officers:
  - Perry Alexion, MD
  - Arkaprava Deb, MD
  - Stefanie Fischell, MD
  - Edith Hambrick, MD

- Doctor Silva recognized Medicare Payment Advisory Commission attendees:
  - Rachel Burton, MPP – Principal Policy Analyst
  - Geoff Gerhardt, MPP – Principal Policy Analyst
  - Brian O'Donnell, MPP – Principal Policy Analyst

- Doctor Silva recognized the new RUC members:
  - Luke Barré, MD - American College of Rheumatology (ACRh)
  - Leisha Eiten, AuD, CCC-A – Health Care Professionals Advisory Committee (HCPAC)
  - Anne Miller, MD – American Society of Surgery for the Hand (ASSH)
  - Sanjay A. Samy, MD - Society of Thoracic Surgeons (STS)

- Doctor Silva recognized the new RUC alternate members:
  - Timothy Laing, MD – American College of Rheumatology (ACRh)
  - James Levett, MD – Society of Thoracic Surgeons (STS)
  - Noah Raizman, MD – American Society of Surgery for the Hand (ASSH)
  - Korinne Van Keuren, DNP, MS, RN – Health Care Professionals Advisory Committee (HCPAC)

- Doctor Silva recognized dedicated departing RUC participant:
  - James Waldorf, MD (ASPS)
  - RUC Member 2008-2025

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

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

- Doctor Silva conveyed the following procedural guidelines related to voting for the RUC:
  - Work RVU and Direct Practice Expense Inputs = 2/3 vote
  - Motions = Majority vote
  - RUC members will vote on all tabs using the single voting link provided via email (Qualtrics).
  - You will need to have access to a computer or smartphone to submit your vote.
  - If you are unable to vote during the meeting, please notify AMA staff.
  - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.

- The RUC votes on every work RVU, including facilitation reports.
- If members are going to abstain from voting, please notify AMA staff so that all 29 votes can be accounted for.
- If specialty society presenters require time to deliberate, please notify the RUC Chair.
- If RUC advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC chair or AMA staff.

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

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

III. Director's Report

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

- Ms. Smith conveyed the following information regarding Subcommittees and Workgroups:
  - The Subcommittee and Workgroup composition are restructured every two years coinciding with the Chair's term.
  - The Subcommittee and Workgroups have been restructured for a new term (March 1, 2025 – February 28, 2027).

- Ms. Smith reviewed the RUC Database application:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets.
  - Download the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - The database reflects 2023 Medicare claims data and the updated 2025 Conversion Factor (CF).
  - Includes more specific Do Not Use to Validate Physician Work Flags.

- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process:
  - The RUC Process webinars may be accessed via the RUC Collaboration home page or by clicking "General Resources" from the left navigation bar and then "New to the RUC" and "RUC Process Webinars & Presentations."

- The RUC Process webinars may also be accessed directly via the YouTube link: https://www.youtube.com/playlist?list=PLpUAhDflHfcoS89T0wxivYpHmsYl8fxZp

- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2027 and 2028 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Aug 26, 2025	Sept 24-27, 2025	Chicago, IL	CPT 2027
Dec 9, 2025	Jan 14-17, 2026	Los Angeles, CA	CPT 2027
Mar 31, 2026	Apr 22-25, 2026	Chicago, IL	CPT 2028

- Ms. Smith announced that the RUC now offers Continuing Medical Education (CME) credits for RUC Meeting Participation:
  - Physicians can earn up to 22.00 AMA *PRA Category 1 Credits*™ and non-physicians can earn a Certificate of Participation.
  - To claim CME credit(s) or Certificate of Participation complete the evaluation provided by AMA Staff at the conclusion of the RUC meeting on or before May 2, 2025.
  - Once you've successfully completed the evaluation, a certificate will be automatically available on May 16, 2025, in the "Transcript" section of your AMA Ed Hub account.

IV. Approval of Minutes from the January 2025 RUC Meeting

The RUC approved the January 2025 RUC meeting minutes as submitted.

V. CPT Editorial Panel Update

Timothy Swan, MD, CPT Editorial Panel Member, provided the following CPT Editorial Panel update on the CPT Ad Hoc Workgroups, and upcoming CPT meeting:

- Panel Meeting Activity
  - RUC Referrals Reviewed at the February 2025 Panel Meeting:
    - Computer Assisted Surgical Navigation Revise 20985 (Tab 7)
    - Prostate Biopsy Services (Tab 16)
    - Autonomic Function Testing (Tab 30)
    - Laser Treatment for Psoriasis-Revise 96920 (Tab 35)

- May 2025 CPT Editorial Panel Meeting
  - 77 Code Change Applications (CCAs) Submitted
    - Notable agenda items:
      - 1 Vaccine CCA for expedited review
      - 7 Digital medicine related CCAs
      - 26 Category III code applications
      - 2 RUC referrals to CPT
      - 4 Codes for CPT Code Set Maintenance
    - RUC Referrals to CPT to be Reviewed at the Upcoming May 2025 Panel Meeting:
      - Femoral Osteoplasty-Delete 27468 (Tab 16)
      - Rotational Vestibular Assessment (Tab 49)

- CPT Ad Hoc Workgroups
    - Maternity Care Services Workgroup
        - Co-Chairs: Padma Gulur, MD and Timothy L. Swan, MD
        - A code change application was submitted by the workgroup with feedback from stakeholders for the May 2025 CPT Editorial Panel Meeting.
        - Currently the proposal includes 12 newly proposed codes and 4 revised codes with 16 code deletions.
        - Four new labor management codes, two vaginal delivery codes, two cesarean delivery codes, one new code for hysterectomy during a cesarean, one new procedure code for uterine tamponade and two new procedure codes for episiotomy repair for 3rd or 4th degree lacerations.
        - The Workgroup is continuing to refine the proposal as appropriate based on Advisor and Interested Party feedback.
        - This request will be reviewed at the May Panel meeting next week.

    - Value Based Care Services Workgroup
        - Co-Chairs: Leo Bronston, DC MAppSc; Samuel Church, MD; Steven Hao, MD
        - The Value-Based Care Services Workgroup was established following the priorities identified during a July 2024 special strategic session of the CPT Editorial Panel. The Workgroup's last meeting was on April 7th. The Workgroup members discussed potential updates to current coding for care management services. The items for discussion included:
            - Revisions to the guidelines to expand the members of the care team whose activities can be included in the overall time of the service when the care team member is under the direction of a physician or other Qualified Health Plan.
            - Clarification regarding the type of supervision of the care team that is required.
            - Removal of time requirements.
        - The workgroup had a good discussion, and it was decided that AMA staff would begin drafting a code change application to expand the language around care-team members to address the staff issue. The group determined that the supervision issue will be addressed through education. The group decided against revising the time requirements for care management services.

- Upcoming CPT Editorial Panel Meetings
    - The next Panel meeting is September 18-20, 2025 (Thursday-Saturday) – Chicago, Illinois
    - The next application submission deadline is June 11, 2025.

VI. Washington Update

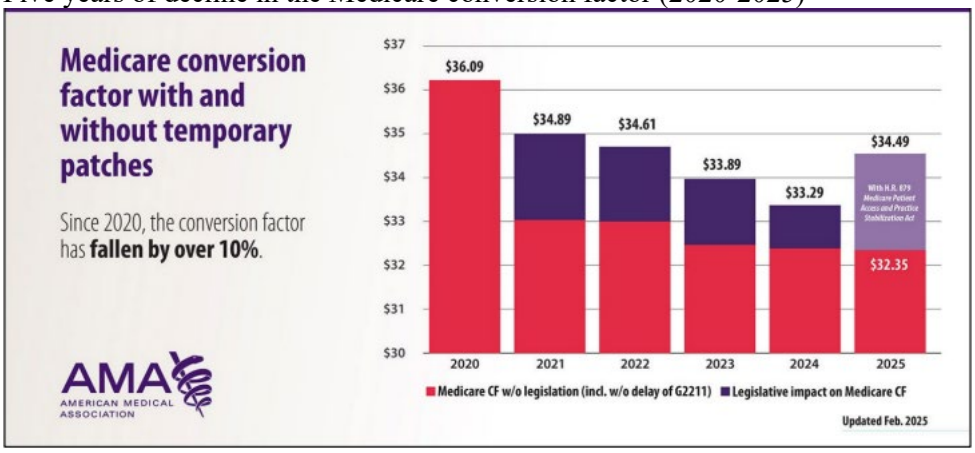
Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, provided the Washington report focusing on AMA Advocacy on Medicare Physician Payment Reform, Telehealth, Medicare Advantage, Regulatory Relief and the New Administration.

- Medicare Payment
    - 2025 Medicare Physician and Qualified Health Professional (QHP) Payment

        - Congress did not address the Medicare pay cut in the short-term Continuing Resolution (CR) that funds the federal government through the end of the fiscal year.
        - Negotiations around the CR primarily focused on avoiding a government shutdown, leaving several key policies such as physicians and QHP payment relief on the sidelines.

    - AMA Statement: Congress abandons Medicare patients and their physicians
        - "Physicians across the country are outraged that Congress's proposed spending package locks in a devastating fifth consecutive year of Medicare cuts, threatening access to care for 66 million Medicare patients. Despite repeated warnings, lawmakers are once again ignoring the dire consequences of these cuts and their impact both on patients and the private practices struggling to keep their doors open."
        - "Today's decision to allow the 2.8 percent cut to go forward is particularly devastating for rural and underserved communities. These physicians and their patients have borne the brunt of the rising practice costs – 3.5 percent this year according to Medicare's own estimate. When adjusted for inflation, Medicare payment to physician practices have dropped 33 percent (PDF) since 2001. Let me be clear: These unsustainable cuts will force more practices to close and leave patients with fewer options for care."
        - "Congress has failed physicians, and Medicare patients will pay the price. The window to reverse this reckless decision is rapidly closing. Lawmakers must explain either why protecting access to quality health care is not a priority or how they plan to fix it."

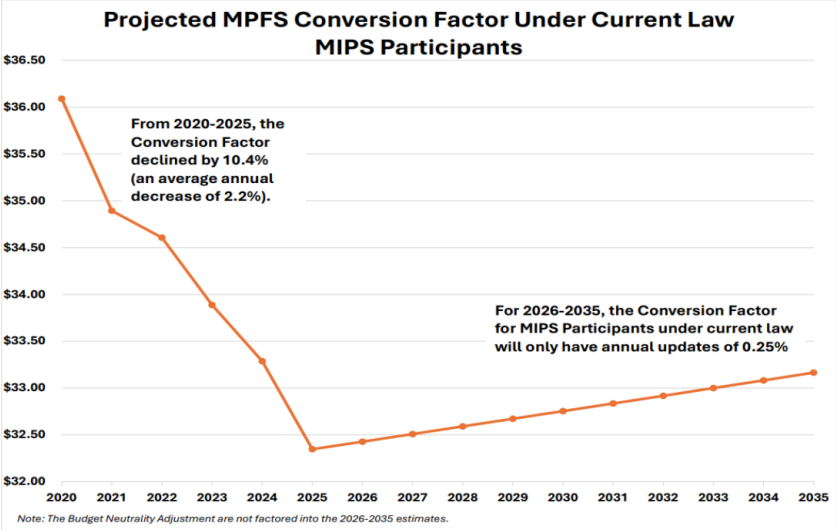
- Five years of decline in the Medicare conversion factor (2020-2025)



- MedPAC Supports Medicare Economic Index (MEI)-Based Payment Updates
  - For the third consecutive year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress permanently update Medicare physician and QHP payment based on a portion of MEI
    - 2024: 50% of MEI
    - 2025: 50% of MEI
    - 2026: MEI minus 1 percentage point
  - AMA President Scott statement: "MedPAC gives Congress a roadmap to Medicare reform"

- MedPAC and Long-Term Medicare Payment Reform
  - MedPAC voted on long-term Medicare physician payment reform recommendations at the April 2025 meeting including replacing current law updates with automatic, annual updates based on a portion of MEI (such as MEI minus 1 percentage point) to include in their June 2025 Report to Congress
  - AMA President Scott statement: "AMA: Congress should listen to MedPAC on Medicare reform"
  - MedPAC will also recommend Congress direct CMS to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflects the costs of delivering care
    - Updating aggregate allocation of RVUs
    - Improving the relative accuracy of global surgical codes
    - Improving the accuracy of payment rates for indirect PE

- Projected Medicare Physician Fee Schedule (MPFS) Conversion Factor Under Current Law Merit-Based Incentive Payment System (MIPS) Participants



- Tell Congress to Support H.R. 879
  - H.R. 879, the Medicare Patient Access and Practice Stabilization Act of 2025
    - Reverses the latest round of Medicare payment cuts providing immediate financial relief to stabilize practices and preserve patient access
    - Provides an inflationary update to ensure payments in 2025 begin to reflect the rising costs of delivering care, a critical step toward sustainable reform
    - Take Action:
      - Email Congress
        - Send a message to your member of Congress and urge them to support Medicare payment reform
      - Spread the Message
        - Copy or customize ready-to-use messages and download graphics to use in social media posts and on your profiles to generate increased #FixMedicareNow campaign awareness
      - Use your Voice
        - Tell us your story and make your voice heard to highlight the importance of Medicare payment reform
      - www.FixMedicareNow.Org

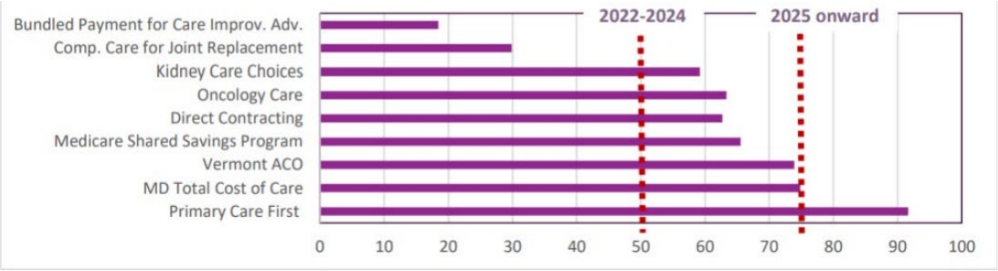
- Alternative Payment Models (APMs)

  - Qualifying APM Participants (QPs) in advanced APMs are exempt from the Merit-based Incentive Payment System (MIPS) and receive incentive payments:
    - 5% incentive payment for performance years 2017-2022
    - 3.5% incentive payment for performance year 2023
    - 1.88% incentive payment for performance year 2024
    - 0.5% higher conversion factor update (0.75% annual update) than everyone else (0.25% annual update) for performance years 2024 and beyond

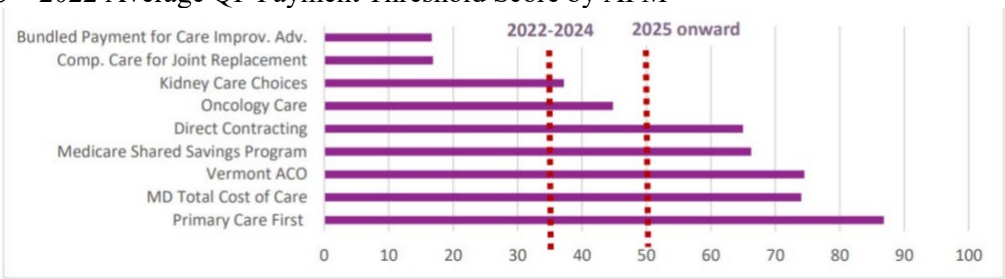
- Under current law, incentive payments expired in 2025 and the QP threshold increased from 50% to 75% of Medicare part B payments or 35% to 50% of Medicare patients through the APM entity

- APM Changes
  - On March 12, 2025, the Centers for Medicare and Medicaid Innovation (CMMI) announced it was ending the following models early by Dec. 31, 2025:
    - Maryland Total Cost of Care (MD expected to transition to AHEAD model)
    - Primary Care First
    - End-Stage Renal Disease (ESRD) Treatment Choices (will propose termination through rulemaking)
    - Making Care Primary
  - CMS proposed changes to the mandatory Transforming Episode Accountability Model (TEAM) that begin in 2026
  - Big picture: Many physicians, especially specialists and those in rural areas, lack access to APMs

- 2022 Average QP Payment Threshold Score by APM



- 2022 Average QP Payment Threshold Score by APM



- AMA Advocacy
  - APMs have a successful track record of improving health outcomes and reducing costs. Extending APM incentives and broadening model availability will promote patient-centered care while maintaining provider choice and reward providers for improving patient health rather than for the volume of services provided.
  - AMA urged Congress to support H.R. 786, the Preserving Patient Access to Accountable Care Act, bipartisan legislation that extends the APM incentive payments at 3.35% for the 2025 performance period and delays the QP threshold increase.
  - AMA joined a coalition of stakeholders urging Congress to extend Medicare's advanced APM incentive payments and stop the drastic QP threshold increase.

- AMA joined a coalition of stakeholders urging MedPAC to stress the importance of continuing APM incentives in its June 2025 Report to Congress.

- Telehealth
  - Congress extended telehealth flexibilities in Medicare through Sept. 30, 2025, in the CR
  - On Feb. 7, AMA urged CMS to add the CPT audio-video and audio-only telehealth codes to the Medicare Telehealth List
    - "Each of the services in this code family is a substitute for an in-person office visit service but is provided via audio-only or audio-video telecommunications. As office visits are specifically defined as "telehealth services" in § 1834(m), these services should be added to the Medicare Telehealth List on a permanent basis."

- Medicare Advantage (MA)
  - 2026 Payment for MA Plans
    - CMS finalized a 5.06% increase or over $25 billion for MA plans in the CY 2026 Final Rate Announcement
      - AMA press statement on Advance Notice in January: "So, while MA plans receive an increase beyond the expected health care inflation rate, Congress not only failed to provide a physician payment update but allowed a new round of cuts at the end of the lame duck. It's unbelievable they're giving insurance companies that had record profits an increase while at the same time cutting payment to physician practices that are struggling to survive. This contrast highlights the urgent need for Congress to prioritize linking payment to physician practices to the cost of providing care. Otherwise, with or without MA plans, patient access will suffer if physicians close their practices. A new Congress is meeting —it's time for a new approach to physician payment reform."
  - 2026 MA & Part D Final Rule Key Takeaways
    - CMS finalized several MA reforms including prior authorization related updates, such as requiring MA plans to honor inpatient prior authorization approvals through discharge and applying appeal rights to decisions made during ongoing treatment.
    - CMS also finalized guardrails for Special Supplemental Benefits for the Chronically Ill (SSBCI), as well as policies to improve the experience for dual-eligible enrollees.
    - However, CMS declined to finalize several key AMA backed proposals, including:
      - Expanded Part D coverage of anti-obesity medications,
      - Expanded guardrails for augmented intelligence,
      - Utilization management reforms aimed at bolstering transparency,
      - Improving the Medicare Plan Finder, and
      - Agent/broker oversight

- MedPAC March 2025 Report to Congress
  - From 2018 to 2024, the share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent to 54 percent.
  - MedPAC estimates that Medicare will spend 20 percent more for MA enrollees in 2025 than it would spend if those beneficiaries were enrolled in Fee-for-Service (FFS) Medicare, a difference that translates into a projected $84 billion.
    - Favorable selection
    - Risk adjustment and coding intensity
  - Higher MA spending increases Part B premiums for all beneficiaries, including those in FFS Medicare

- Regulatory Relief

  - Executive Orders and Memos
    - On Jan. 31, President Trump signed Executive Order 14192 declaring "the policy of the executive branch" to be that federal agencies should "alleviate unnecessary regulatory burdens placed on the American people" and directing agencies to identify 10 existing regulations to be repealed whenever one is publicly proposed for notice and comment.
    - On Feb. 19, President Trump signed Executive Order 14219 directing agencies to "initiate a process to review all regulations" and identify regulations that, among other things, "impose undue burdens on small businesses and impede private enterprise and entrepreneurship."
    - On April 9, the President issued a Presidential Memorandum directing agencies to identify unlawful and potentially unlawful regulations and take immediate steps to effectuate the repeal of any regulation, or the portion of any regulation, that clearly exceeds the agency's statutory authority or is otherwise unlawful. "The repeal of each unlawful regulation shall be accompanied by a brief statement of the reasons that the "good cause" exception applies."

  - AMA Advocacy and Agency Requests for Input
    - On Feb. 24, the AMA wrote to CMS outlining the opportunities for regulatory relief in the Merit-based Incentive Payment System (MIPS).
    - The Department of Justice (DOJ) Anticompetitive Regulations Task Force is seeking comment by May 26 on "laws and regulations that make it more difficult for businesses to compete effectively, especially in markets that have the greatest impact on American households," including in health care.
    - The White House Office of Management and Budget (OMB) issued a request for information (RFI) with a 30-day comment deadline about "regulations that are unnecessary, unlawful, unduly burdensome, or unsound" and proposals to rescind or replace those regulations.
    - CMS issued a RFI seeking input on opportunities to streamline regulations and reduce burdens on physicians and QHPs.

- New Administration
    - Administrator Oz: Vision for CMS
        - Empowering the American people with personalized solutions they can better manage their health and navigate the complex health care system. As a first step, CMS will implement the President's Executive Order on Transparency to give Americans the information they need about costs.
        - Identifying and eliminating fraud, waste, and abuse to stop unscrupulous people who are stealing from vulnerable patients and taxpayers.
        - Equipping health care providers with better information about the patients they serve and holding them accountable for health outcomes, rather than unnecessary paperwork that distracts them from their mission. For example, CMS will work to streamline access to life saving treatments.
        - Shifting the paradigm for health care from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management. For example, CMS operates many programs that can be used to focused on improving holistic health outcomes.
        - AMA letter to congratulate Dr. Oz and offer to be a resource

VII. Relative Value Recommendations for CPT 2027

Ablation Therapy – Bone Tumors (Tab 4)
Curtis Anderson, MD (OEIS), Michael Booker, MD (ACR), William Creevy, MD (AAOS), Robert Kennedy, MD (SIR),
In February 2025, the CPT Editorial Panel approved a new Category I add-on code to describe and report cryoablation during an open surgical procedure where the bone is frozen after a tumor resection. The physician work involves applying liquid nitrogen into the bone defect to freeze it. Typically, this is utilized for large or complex tumors rather than percutaneous methods, where a device or a probe is put through the skin. The new add-on code was surveyed for the April 2025 RUC meeting.

Family of Services
Despite all three codes involving bone tumors, the specialty societies indicated that percutaneous approach CPT codes 20982 and 20983 are not part of the same code family as the new open approach add-on code 209XX. In preparation for the April 2025 RUC meeting, the specialty societies submitted a letter to the RUC that provides a detailed explanation about how these codes are dissimilar and a comprehensive rationale supporting their decision to survey only CPT code 209XX and not the other two existing codes. CPT codes 20982 and 20983 both describe stand-alone percutaneous procedures for radiofrequency ablation (20982) and cryoablation (20983), whereas 209XX describes an add-on open procedure performed after surgical curettage of the bone tumor. Thus, the two percutaneous procedures are not clinically similar to 209XX and do not require comparable physician work. Both percutaneous procedures are performed by a small number of physicians overall, and among the physicians who use these codes, the annual case volumes are relatively low. The specialty societies reiterated the substantial differences between the stand-alone percutaneous procedures and the new add-on open bone tumor ablation procedure. They also confirmed this would not create a rank order anomaly across these services. **The RUC agreed with the specialty societies that CPT codes 20982 and 20983 are not in the same code family and do not need to be resurveyed with CPT code 209XX for the April 2025 RUC meeting. The RUC submits no recommendation for CPT codes 20982 and 20983. The RUC notes that a small percentage (15%) of these services were reported incorrectly, rather than an unlisted code for**

the open approach. As such, a small budget neutrality adjustment is included in the RUC's utilization assumptions.

ZZZ Survey Template
The specialty societies submitted a second letter to the RUC, indicating their intention to make an interim recommendation for CPT code 209XX at the April 2025 RUC meeting until this code can be resurveyed for the September 2025 RUC meeting using a different survey instrument. In their rationale, the specialty societies explained that the standard ZZZ survey instrument used to survey CPT code 209XX did not provide survey respondents with the opportunity to accurately account for and estimate any potential pre-service and post-service time required to perform this service. In rare circumstances, specialty societies may provide justification and request that an amended ZZZ survey instrument with pre- and post-service time be used when surveying.

In their explanation, the specialty societies described that the pre-service work involved with CPT code 209XX includes further discussion with the patient, which includes describing the ablation therapy and outlining potential risks, particularly to the adjacent tissues and structures. Additional time is also needed to ensure the medical team is set up and fully prepared to perform this procedure, which is rarely done and requires using a variety of supplies for handling liquid nitrogen, including funnels, silicone sheets to place around soft tissues, and special types of protective goggles and gloves. The intra-service time involved with this service includes the placement of the protective silicone sheets, attaching a probe or thermocouple to monitor the temperature and the extent of freezing, carefully pouring the liquid nitrogen into the defect through a funnel, letting it sit and freeze the bone for 5-6 minutes, administering warm saline around the soft tissue as necessary to avoid freezing damage, and drying the bone to complete the freeze-thaw cycle. This cryoablation cycle is repeated three times.

Considering that the standard ZZZ survey instrument only has a single field to enter intra-service time, the specialty societies believe this may have confused survey respondents and led to a potential underestimation of the pre-service, post-service, and total time necessary to perform this procedure. Due to this potentially being a flawed survey, the specialty societies prepared an interim recommendation for CPT code 209XX using the current survey results. They intend on resurveying for the September 2025 RUC meeting using an amended ZZZ survey instrument with pre- and post-serve time, which would provide survey respondents with the opportunity to report additional pre- and/or post-service time if applicable. **The RUC determined that the specialty societies may survey 209XX with the amended ZZZ survey template that specifically asks the respondent whether pre- and post-service time is associated with this add-on service for the September 2025 RUC meeting.**

209XX ***Ablation therapy for reduction or eradication of bone tumor, including adjacent soft tissue when involved by tumor extension, cryoablation, open (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 37 orthopaedic surgeons who are self-designated as musculoskeletal oncologists and recommends an interim work RVU of 2.78, which is consistent with the survey 25th percentile work RVU and appropriately accounts for the physician work typically required to perform this service. The RUC recommends 25 minutes of intra-service and total time.

To support the recommended work RVU of 2.78, the RUC compared the surveyed code to the top key reference code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU = 2.50, 25 minutes intra-service time, 32 minutes total time) and the second key reference code 61797 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion,*

simple (List separately in addition to code for primary procedure) (work RVU = 3.48, 30 minutes intra-service and total time). The RUC recognizes that the two key reference services bracket the survey 25th percentile work RVU and estimated measured intensity. The surveyed code requires identical intra-service time compared to the top key reference code, but also has greater complexity and intensity to perform, thus supporting a higher work RVU. Survey respondents who selected the top key reference also agreed that the surveyed code is more intense/complex to perform. CPT code 209XX requires slightly less time and intensity compared to the second key reference code, further supporting the survey 25th percentile work RVU. **The RUC recommends an interim work RVU of 2.78 for CPT code 209XX and a resurvey with the pre/post time ZZZ survey template for review at the September 2025 RUC meeting.**

Practice Expense
The RUC recommends no direct practice expense inputs for CPT code 209XX as it is a facility-based add-on service.

New Technology
CPT code 209XX will be placed on the New Technology/New Services list to be re-reviewed by the RUC in three years. The specialty societies expect this to be a low-volume service. Given that this procedure describes open cryosurgery and involves liquid nitrogen, the technology utilized, and the technique involved with these supplies are not widely practiced and are unfamiliar to most orthopaedic surgeons at this time.

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

Computer Assisted Surgical Navigation (Tab 5)
William Creevy, MD (AAOS)

In April 2024, the Relativity Assessment Workgroup identified CPT code 20985 as part of the high-volume growth screen, with Medicare utilization over 10,000 that has increased by at least 100% from 2017 through 2022. Separately, codes 0054T *Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)* and 0055T *Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)* had been identified on the high-volume CPT Category III screen and were referred for repeat evaluation in three years because the current literature was not sufficient for Category I code status. The specialty society noted that codes 20985, 0054T, and 0055T represented the same service if minor changes were made in the 20985 code descriptor. In September 2024, the Workgroup reviewed the action plan for 20985 and recommended that the RUC refer this code to the CPT Editorial Panel for revision. The RUC recommended that CPT code 20985 be referred to CPT for revision to modify the descriptor and address overlap with codes 0054T and 0055T. At the February 2025 CPT Editorial Panel meeting, CPT code 20985 was revised to remove "image-less" for reporting computer-assisted surgical navigational procedures for musculoskeletal procedures. The two existing Category III codes will be deleted for CPT 2027. CPT code 20985 and related family (eg, 20985 is reported with 27447 76% of the time) codes were identified for review at the April 2025 RUC meeting.

Family of Services
The specialty societies indicated that CPT codes 20985, 27130, 27446 and 27447 are not a family of services as 20985 is an add-on code that can be reported with hundreds of different musculoskeletal procedures. The RUC noted that 20985 is reported 76 percent of the time with 27447. However, as 27447 has much more volume than 20985, only 18 percent of the claims that have 27447 also include 20985. The other joint arthroplasty codes are also currently not typically reported with computer-assisted surgical navigation. AMA staff noted that CMS has an expectation that add-on codes are reviewed along with base codes, with which they are typically performed. At this meeting, CPT codes 27130 and 27447 have been separately identified in a Relativity Assessment Workgroup site of service anomaly screen for services that are typically outpatient, though still have inpatient visits. The specialty society indicated that they will be surveying these services for the September 2025 RUC meeting. Due to this separate identification, all four services will be reviewed at the same meeting. **The RUC recommends that 27130, 27446 and 27447 be reviewed at the September 2025 RUC meeting.**

ZZZ Survey Template
CPT code 20985 was surveyed for pre-and post-time in 2012 and include 10 minutes of pre-service time. CPT codes 20985 was surveyed this time with the standard ZZZ survey template, which specifies the ZZZ global period as a *code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-service time and in some instances the pre-and post-service time)* and only asks for the day of procedure intra-service time. In rare circumstances, specialties may provide justification and request that a ZZZ survey with pre- and post-service time be conducted. The specialty societies are requesting to resurvey these services with the pre/post ZZZ survey template.

The specialties indicated that they believe the pre-service time that was captured in the 2012 valuation remains an integral part of this work for these services. The specialty noted that they are using computer navigation and the associated risk with the patient. The associated risk is related to the need to make additional small incisions for placement of reference pins into bone and associated risks of infection, fracture, and neurovascular injury. There is also additional pre-service time required to initiate and calibrate computer navigation equipment, as well as additional patient positioning time for the computer navigation to be used. **The RUC determined that the specialty societies may survey 20985 with the amended ZZZ survey template that specifically asks the respondent whether this is pre- and post-service time associated with these add-on services.**

20985 ***Computer-assisted surgical navigational procedure for musculoskeletal procedures (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 113 orthopaedic surgeons and recommends an interim work RVU of 2.50, maintaining the current value. As interim, the RUC recommends 0 minutes pre-service time and 25 minutes intra-service time, totaling 25 minutes. The specialty societies did not survey for pre-service time and have requested to resurvey with an amended survey instrument, specifically asking if separate pre-service time from the base code occurs for this service.

The RUC compared the surveyed code to the top key reference code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service 25 minutes and total time 32 minutes) and determined that with identical intra-service times, both services typically involve the same amount of physician work. Of the survey respondents who selected this key reference code, 79 percent indicated that the surveyed code is more intense than key reference code 20702.

For additional support the RUC referenced CPT code 33268 *Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)* (work RVU= 2.50, 20 minutes intra-service and total time). **The RUC recommends an interim work RVU of 2.50 for CPT code 20985 and resurvey with the pre/post time ZZZ survey template for review at the September 2025 RUC meeting.**

Practice Expense
The RUC recommends no direct practice expense inputs for CPT code 20985 as it is a facility-based add-on service.

Division of Median Arcuate Ligament (Tab 6)
Charles Mabry, MD (ACS), Dmitry Nepomnayshy, MD (SAGES), Don Selzer, MD (ACS), Jonathan Thompson, MD (SVS)

At the February 2025 CPT Editorial Panel meeting, two new codes were created to report open and laparoscopic median arcuate ligament syndrome (MALS) treatment, respectively. MALS or celiac artery compression syndrome is an uncommon vascular disorder caused by an extrinsic compression of the celiac artery from the median arcuate ligament, prominent fibrous bands, and ganglionic periaortic tissue. These infrequent but constant procedures have been performed for several decades and reported with unlisted codes. The two new codes were surveyed for the April 2025 RUC meeting.

39XX1 ***Division of median arcuate ligament and release of celiac trunk, with ganglionectomy, when performed***
The RUC reviewed the survey results from 36 surgeons and recommends a work RVU of 27.09 based on a direct crosswalk to CPT code 35601 *Bypass graft, with other than vein; common carotid-ipsilateral internal carotid* (work RVU = 27.09, 180 minutes intra-service, and 484 minutes total time), which maintains relativity within the family for this code. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes positioning time, 15 minutes scrub/dress/wait time, 160 minutes intra-service time, 30 minutes immediate post-service time, 2-99231, 1-99232, 1-99233, 1-99239, 1-99213, 1-99214, totaling 501 minutes. The 5-day hospital stay is necessary for the patient, who is typically in an anorexic state and extremely underweight, to be monitored for their ability to tolerate adequate oral intake of food to ensure safe discharge. The re-establishment of oral food intake is sufficiently complex where management of this problem typically extends into the office visits.

For this open procedure, the median arcuate ligament lies directly over the aorta, which significantly increases the complexity and intensity of dissecting the celiac axis. This procedure necessitates a large upper midline laparotomy with the use of mechanical retractors to access the upper posterior portion of the abdomen. Although injury to the aorta, phrenic vessels, or diaphragm is not common, the potential for such injury is possible. Preparation for emergency maneuvers and intraoperative attention to possible injury is constant, significantly increasing the intensity of the procedure. Compared to the laparoscopic procedure, 39XX2, CPT code 39XX1 requires more time during the post-operative period; therefore, is valued slightly higher.

To support the recommended work RVU, the RUC referenced codes 49187 *Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5.1 to 10 cm* (work RVU = 28.65, 195 minutes intra-service, and 542 minutes total time) and 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60, 180 minutes intra-service, and 424 minutes total time). The surveyed code work RVU

and total time are appropriately bracketed by the key reference services supporting the relativity of the RUC recommended work RVU.

For additional support, the RUC referenced code 35506 *Bypass graft, with vein; carotid-subclavian or subclavian-carotid* (work RVU = 25.33, 165 minutes intra-service, and 452 minutes total time) and MPC code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service, and 512 minutes total time). The surveyed code work RVU, intra-service time, and total time are appropriately bracketed by the reference codes supporting the relativity of the RUC recommended work RVU. **The RUC recommends a work RVU of 27.09 for CPT code 39XX1.**

39XX2 ***Laparoscopy, surgical, with division of median arcuate ligament and release of celiac trunk, with ganglionectomy, when performed***
The RUC reviewed the survey results from 37 surgeons and recommends a work RVU of 26.60 based on a direct crosswalk to CPT code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60, 180 minutes intra-service, 424 minutes total time), which maintains relativity within the family for this code. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes positioning time, 10 minutes scrub/dress/wait time, 180 minutes intra-service time, 30 minutes immediate post-service time, 1-99231, 1-99232, 1-99238, 1-99213, 1-99214, totaling 436 minutes. The additional pre-service positioning time is required to secure the patient to the table during manipulation to provide better exposure. The 3-day hospital stay is necessary for the patient, who is typically in an anorexic state and extremely underweight, to be monitored for their ability to tolerate adequate oral intake of food to ensure safe discharge. The reestablishment of oral food intake is so challenging that management of this problem extends into the office visits.

For this laparoscopic procedure, the median arcuate ligament lies directly over the aorta, which significantly increases the complexity and intensity of dissecting the celiac axis. This procedure uses similar types of mechanical retraction to elevate the liver, and delicate dissections around the three branches of the celiac trunk are performed. Although injury to the aorta, phrenic vessels, or diaphragm is not common, the potential for such injury is possible. Preparation for emergency maneuvers and intraoperative attention to possible injury is constant, significantly increasing the intensity of the procedure.

To support the recommended work RVU, the RUC referenced MPC codes 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU = 22.46, 180 minutes intra-service, and 362 minutes total time) and 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service, and 512 minutes total time). The surveyed code work RVU and total time are appropriately bracketed by the reference services supporting relativity of the RUC recommended work RVU. **The RUC recommends a work RVU of 26.60 for CPT code 39XX2.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

Transoral Oropharyngeal Procedures (Tab 7)
Brian Boyce, MD (AAO-HNS), Peter Manes, MD (AAO-HNS)

In February 2025, the CPT Editorial Panel approved two new Category I codes that describe transoral endoscopic surgery under magnification for the removal of tumors in the oropharynx, including robotic assistance (when performed). Transoral Robotic Surgery (TORS) is a new technique for transoral resection that has become the standard of care for this sort of physician work. After creating the two new Category I codes that described transoral resection of oropharyngeal tumors under magnification, CPT code 42808 was revised to clarify that it is done without magnification. CPT code 42808 was included in the family of procedures to be surveyed for the April 2025 RUC meeting.

42808 ***Excision or destruction of lesion of pharynx, without magnification, any method***
The RUC reviewed survey results from 37 head and neck surgeons and recommends the current work RVU of 2.35, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 25 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes scrub/dress/wait time, 32 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge day visit, and 1-99212 office visit, which equals 125 minutes of total time.

The specialty society recommended pre-service time package *3-FAC Straightforward Patient/Difficult Procedure* and post-service time *package 9A General Anes or Complex Reg Blk/Strghtforw Proc.* The specialty society modified the selected time packages to align with the pre-service and post-service time as indicated by the survey respondents. The RUC noted that 42808 is typically provided in the outpatient setting and agreed that one 99212 office visit and a half-day discharge visit is appropriate.

To support the recommended work RVU of 2.35, the RUC compared the surveyed code to the top key reference code 17272 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm* (work RVU = 1.82, 22 minutes intra-service time, 52 minutes total time) and the second key reference code 12034 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm* (work RVU = 2.97, 45 minutes intra-service time, 85 minutes total time). The RUC recognizes that the top key reference service requires significantly less time than the surveyed code and appropriately has a lower work RVU. Moreover, the second key reference service has a greater work RVU because it requires more intra-service time, albeit less overall total time, and is more intense/complex for the physician to perform compared to the surveyed code.

For additional support, the RUC referenced MPC code 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm* (work RVU = 4.00, 45 minutes intra-service time, 85 minutes total time). This MPC reference code requires more intra-service time and physician work at a greater intensity/complexity, thus it has a greater work RVU than the surveyed code. **The RUC recommends a work RVU of 2.35 for CPT code 42808.**

42XX1 ***Transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification (eg, microscope or telescope), includes robotic assistance, when performed, tongue base***
The RUC reviewed survey results from 37 head and neck surgeons and recommends the survey median work RVU of 20.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 20 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 3-99232 hospital visits, 1-99239 discharge day visit, and 3-99213 office visits, which equals 469 minutes of total time.

The RUC agreed with survey respondents' inclusion of three hospital visits during the patient's multi-day hospital stay, a full discharge management visit, and three follow-up office visits to accurately account for the considerable post-operative work involved following this major surgical procedure. During the full discharge management visit, discussion of an aftercare treatment plan with the patient occurs, which includes coordinating tube feeding supplies for patients who need supplemental nutrition, home care instructions for management of the nasogastric (NG) tube and other daily living activities, as well as post-discharge follow-up professional services and testing as necessary. The first office visit involves removing the NG tube, coordinating post-operative radiation and medical oncology as indicated, and discussion of final pathology reports and post-operative adjuvant therapy needs, in addition to diet discussions with a nutritionist and standard post-operative monitoring and care coordination. The second and third office visits are necessary for ongoing monitoring of the adequacy of airway and swallowing due to radiation and chemotherapy, as well as routine surveillance for detection of tumor recurrence.

CPT code 42XX1 involves excision of tongue-based lesions. In their rationale, the specialty society discussed the history of this surgical procedure and noted that despite the use of a robot, the intensity/complexity of this service is greater under magnification than it was historically via traditional open surgery. When performed in an open fashion in the past, the lower jaw was cut with a saw, and the mandible was split; swinging open the mandible would allow for clearer access to tumors of the oropharynx. While this was very morbid for the patient, it was easier to perform from a technical perspective compared to the transoral robotic approach. The open approach allows for a wider field of work and view, as well as direct control of the vasculature. In the event there is bleeding, the field of view is wide enough to allow for easier visualization and control. In terms of tumor excision, the surgeon can have a wider field with which to work, thus making surgical movements easier due to the increased room. This also allows for tactile feedback when addressing the tumors.

CPT code 42XX1 is a more difficult procedure to perform compared to other existing open surgical pharyngectomy codes for a variety of reasons. The surgery is inverted for the physician, meaning the physician uses instruments posteriorly and inferiorly through the oral cavity to the base of the tongue, which can be challenging and disorienting. There are no anatomic landmarks throughout the tongue and no surgical planes. The physician must cut through the flesh until they reach the lingual airway and hypoglossal nerve, which is preserved. When making the inferior cut, the surgeon cuts through the vallecula, which is the top of the patient's airway. This is very intense/complex because if the surgeon performs too much manipulation here, it could lead to significant airway swelling. Additionally, when compared to the open procedure approach, there is no tactile feedback with this TORs procedure. The surgeon is completely reliant on robotic visualization, which is limited and typically has small amounts of blood obscuring the field. Notably, TORs reportedly have a 1.3% patient mortality 90 days post-surgery, which speaks to the overall intensity/complexity of this procedure.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure* and post-service time *package 9B General Anes or Complex Regional Blk/Cmplx Proc.* The specialty societies made modifications to the selected time packages to more accurately reflect pre-service and post-service time as indicated by the survey respondents. This includes 20 minutes of pre-service positioning time, which is 17 minutes above the selected pre-service time package but 5 minutes less than the survey median time. The specialty society indicated that the additional positioning time is justified because the procedure requires the use of mouth props and retractors to properly visualize the anatomy. Additional positioning time is needed to set up the robot used during this procedure. The RUC agreed with the changes to the time packages and that 3-99232 hospital visits, 1-99239 discharge day visit, and 3-99213 office visits were appropriate based on the presented rationale.

To support the recommended work RVU of 20.00, the RUC compared the surveyed code to the top key reference code 43332 *Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis* (work RVU = 19.62, 150 minutes intra-service time, 482 minutes total time) and second key reference code 15738 *Muscle, myocutaneous, or fasciocutaneous flap; lower extremity* (work RVU = 19.04, 150 minutes intra-service time, 516 minutes total time). The RUC recognizes that though the surveyed code has less intra-service and total time than both key reference services, survey respondents considered it significantly more intense/complex to perform. In their discussion, the RUC also compared the surveyed code to CPT codes 44125 *Enterectomy, resection of small intestine; with enterostomy* (work RVU = 20.03, 120 minutes intra-service time, 524 minutes total time) and 27415 *Osteochondral allograft, knee, open* (work RVU = 20.00, 120 minutes intra-service time, 424 minutes total time). Compared to CPT code 42XX1, both reference codes have nearly identical work RVUs, identical intra-service time, and support 42XX1 in terms of total time and relative intensity/complexity.

For additional support, the RUC also referenced MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time, 404 minutes total time), which involves identical intra-service time as CPT code 42XX1. This reference service requires less time than the surveyed code but requires a greater relative intensity to perform. The survey median work RVU for 42XX1 preserves relativity within the Medicare Fee Schedule. **The RUC recommends a work RVU of 20.00 for CPT code 42XX1.**

42XX2 ***Transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification (eg, microscope or telescope), includes robotic assistance, when performed; tongue base; lateral pharyngeal wall, including tonsil***

The RUC reviewed survey results from 38 head and neck surgeons and recommends the survey median work RVU of 20.05, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 20 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 3-99232 hospital visits, 1-99239 discharge day visit, and 3-99213 office visits, which equals 469 minutes of total time.

The RUC agreed with survey respondents' inclusion of three hospital visits during the patient's multi-day hospital stay, a full discharge management visit, and three follow-up office visits to accurately account for the considerable post-operative work involved following this major surgical procedure. During the full discharge management visit, discussion of an aftercare treatment plan with the patient occurs, which includes coordinating tube feeding supplies for patients who need supplemental nutrition, home care instructions for management of the nasogastric (NG) tube and other daily living activities, as well as post-discharge follow-up professional services and testing as necessary. The first office visit involves removing the NG tube, coordinating post-operative radiation and medical

oncology as indicated, and discussion of final pathology reports and post-operative adjuvant therapy needs, in addition to diet discussions with a nutritionist and standard post-operative monitoring and care coordination. The second and third office visits are necessary for ongoing monitoring of the adequacy of airway and swallowing due to radiation and chemotherapy, as well as routine surveillance for detection of tumor recurrence.

CPT code 42XX2 involves the removal of lateral pharyngeal wall lesions, including the tonsil. In their rationale, the specialty society discussed the history of this surgical procedure and noted that despite the use of a robot, the intensity/complexity of this service is greater under magnification than it was historically via traditional open surgery. When performed in an open fashion in the past, the lower jaw was cut with a saw, and the mandible was split; swinging open the mandible would allow for access to tumors of the oropharynx. While this was very morbid for the patient, it was easier to perform from a technical perspective compared to the transoral robotic approach. The open approach allows for a wider field of work and view, as well as direct control of the vasculature. In the event there is bleeding, the field of view is wide enough to allow for easier visualization and control. In terms of tumor excision, the surgeon can have a wider field with which to work, thus making surgical movements easier due to the increased room to make them. This also allows for tactile feedback when addressing the tumors.

CPT code 42XX2 is a more difficult procedure to perform compared to other existing open surgical pharyngectomy codes for a variety of reasons. The surgery is inverted for the physician, meaning the physician uses instruments posteriorly and inferiorly through the oral cavity to the base of the tongue, which can be challenging and disorienting. There are no anatomic landmarks throughout the tongue and no surgical planes. The physician must cut through the flesh until they reach the lingual airway and hypoglossal nerve, which is preserved, but there are no specifically identifiable anatomic landmarks. When making the inferior cut, the surgeon cuts through the vallecula, which is the top of the patient's airway. This is very intense/complex because if the surgeon does too much work and manipulation here, it could lead to significant airway swelling. Additionally, when compared to the open procedure approach, there is no tactile feedback with this TORs procedure. The surgeon is completely reliant on robotic visualization, which is limited and typically has small amounts of blood obscuring the field. Notably, TORs reportedly have a 1.3% patient mortality 90 days post-surgery, which speaks to the overall intensity/complexity of this procedure.

Compared to CPT code 42XX1, CPT code 42XX2 is nearly identical in terms of the physician work involved with this service, aside from the fact that it involves removal of lateral pharyngeal wall lesions, including the tonsil, while 42XX1 specifically involves excision of tongue-based lesions. The recommended survey median work RVU for 42XX2 is 20.05 compared to 20.00 for 42XX1. The specialty society attributed this slight increase to the increased risk of bleeding with surgery involving the tonsil. As the surgeon approaches the lateral pharyngeal wall, there is a great risk of going too deep near the carotid artery. Being that this is a tumor resection and not a child's tonsillectomy, the surgeon must try to get clear margins. This distinction explains why survey respondents likely considered recommending a slightly greater work RVU for 42XX2 compared to 42XX1.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure* and post-service time *package 9B General Anes or Complex Regional Blk/Cmplx Proc.* The specialty societies modified the selected time packages to more accurately reflect pre-service and post-service time, as indicated by the survey respondents. This includes 20 minutes of pre-service positioning time, which is 17 minutes above the selected pre-service time package but 5 minutes less than the survey median time. The specialty society indicated that the additional positioning time is justified because the procedure requires the use of mouth props and retractors to properly visualize the anatomy. Additional positioning time is needed to set up the robot used during this procedure. The

RUC agreed with the changes to the time packages and that 3-99232 hospital visits, 1-99239 discharge day visit, and 3-99213 office visits were appropriate based on the presented rationale.

To support the recommended work RVU of 20.05, the RUC compared the surveyed code to the top key reference code 15738 *Muscle, myocutaneous, or fasciocutaneous flap; lower extremity* (work RVU = 19.04, 150 minutes intra-service time, 516 minutes total time) and second key reference code 15733 *Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)* (work RVU = 15.68, 120 minutes intra-service time, 305 minutes total time). The RUC recognizes that the top key reference service requires more intra-service time and total time than the surveyed code, but is much less intense/complex to perform, and thus it is appropriate that it has a lower work RVU. Compared to the second key reference service, the surveyed code requires identical intra-service time but significantly less total time overall, which justifies why 42XX2 has a greater work RVU.

For additional support, the RUC referenced MPC 47605 *Cholecystectomy; with cholangiography* (work RVU = 18.48, 135 minutes intra-service time, 490 minutes total time). Due to the increased relative intensity/complexity of 42XX2, it is appropriate that it has a greater work RVU than CPT code 47605. The survey median for CPT code 42XX2 preserves relativity within the Medicare Fee Schedule. **The RUC recommends a work RVU of 20.05 for CPT code 42XX2.**

Practice Expense
The Practice Expense (PE) Subcommittee agreed there is compelling evidence to support an increase over the aggregate current cost for clinical staff time, supplies, and equipment. CPT code 42808 had previously never been reviewed by the RUC for work or practice expense. Changes in intra-service time, equipment formulas/standards, and post-operative monitoring time have increased the total time for CPT code 42808 when performed in the office, increasing the total time attributed to practice expense equipment inputs. **The PE Subcommittee approved compelling evidence based on flawed methodology.**

The PE Subcommittee reviewed the direct practice expense inputs and made several modifications. The Subcommittee considered CA022 *Monitor patient following procedure/service, multitasking 1:4* for CPT code 42808. The specialty society justified the 15 minutes of monitoring time as the surgeons are operating in the back of the airway, so there is potential for post-op swelling, requiring the patient to be monitored for an hour post-procedure in the non-facility. The specialty also confirmed that 15 minutes for CA026 *Clean surgical instrument package* is appropriate as it is the standard for cleaning instruments in the medium surgical instrument package. The PE Subcommittee removed the minutes from CA037 *Conduct patient communications* since two phone calls are typically provided with the 99212 post-operative visit. In addition, the equipment formula for EQ170 *light, fiberoptic headlight w-source* and EF008 *chair with headrest, exam, reclining* was revised to include the full amount of time for the procedure, including the post-operative office visit. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 42XX1 and 42XX2 will be placed on the New Technology list to be reviewed by the RUC in three years. Given that these procedures describe a new technique of transoral en bloc resection of oropharyngeal tumors under magnification with the use of a robot, this is not yet widely practiced and relatively unfamiliar to many head and neck surgeons at this time.

Unattended Sleep Testing (Tab 8)
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In April 2024, CPT code 95800 was identified via the high-volume growth screen, with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. The Relativity Assessment Workgroup (RAW) requested that the specialty societies submit an action plan for codes for September 2024. In September 2024, the RUC recommended to refer the code family to CPT for revision. The specialty societies submitted a CPT code change application for the September 2024 CPT meeting to delete the current code family and replace it with a set of codes that more accurately reflect current medical practice and technologies. However, the tab was withdrawn at CPT due to coding structure issues identified by the Panel reviewers. At the February 2025 CPT Editorial Panel meeting, six codes were added to report unattended sleep study with set-up, data acquisition, and technical analysis, and with interpretation and report by a physician or other qualified health care professional. The three existing codes were deleted (95806, 95800, 95801). The new codes were surveyed for the April 2025 RUC meeting.

Compelling Evidence
The specialty societies presented compelling evidence to support a change in physician work due to changes in technique, knowledge, and technology. Deleted CPT codes 95800, 95801, and 95806 were originally established to report unattended sleep testing. However, these codes were originally established to test solely for obstructive sleep apnea and were specific to devices that captured the parameters included in the code descriptors. The new CPT codes 95X18, 95X19, 95X20, 95X21, 95X22, and 95X23 have been developed to capture new devices and new technologies that include varying numbers of leads, channels and parameter categories, and allow for different data capture. Further, the number of leads, channels and parameter categories changes the amount of time that technologists and physicians or QHPs spend. As with more channels and or parameters to review, additional time is required. **The RUC accepted compelling evidence based on a change in physician work due to changes in technique, knowledge, and technology.**

Code Family
CPT codes 95X18, 95X19, 95X20 may only be reported when the raw data is reviewed and includes the set-up, data acquisition, device-generated analysis, and technical analysis. Technical analysis refers to the review and scoring of the data produced by the unattended sleep testing device by a technologist or QHP. These codes represent the technical component of this code family and are practice expense only. Under the prior code structure (95806, 95800 and 95801), technical component only work would be reported by appending the -TC modifier to the former CPT codes.

CPT codes 95X21, 95X22, 95X23 may only be reported when the raw data is reviewed, and the interpretation is completed and documented by a physician or other QHP. Code selection is determined by counting the number of channels and the number of parameter categories reviewed by the physician or other QHP. These codes represent the professional component of this code family and encompass the physician work to provide the services. Under the prior code structure (95806, 95800 and 95801), professional component only work would be reported by appending the -26 modifier to the former CPT codes.

Further, the low complexity codes are for devices with the minimal number of channels and parameters required to diagnose the presence of sleep disordered breathing. Moderate complexity codes cover devices that provide greater characterization of the disorders and information that influences treatment decisions. High complexity studies look for multiple disorders that home devices

previously were incapable of rendering a diagnosis. For context, channel refers to a specific type of data collection pathway used to monitor and display physiological signals during sleep. Channels may include measurements of airflow, respiratory effort, blood oxygen levels, heart rate, heart rhythm, and brain activity, among others. A channel must capture data that provides physiologic information clinically relevant to the disorder(s) being evaluated and the data is viewed over the course of the study. Further, parameters are grouped into categories according to the disorders or physiologic processes they describe. For example, all obstructive respiratory parameters (eg, apnea-hypopnea index [AHI)] respiratory disturbance index [RDI], peripheral arterial tone apnea-hypopnea index [pAHI]) are grouped into a single category because they describe obstructive breathing events or patterns.

95X21 ***Unattended sleep study, interpretation and report by a physician or other qualified health care professional; low complexity of 3-4 channels that generate at least 3-5 parameter categories***
The RUC reviewed the survey results from 93 physicians and recommends a work RVU of 0.83, which is lower than the survey 25th percentile work RVU of 0.90, based on a direct crosswalk to CPT code 72265 *Myelography, lumbosacral, radiological supervision and interpretation* (work RVU = 0.83, 15 minutes intra-service time, and 25 minutes total time). The RUC recommends 5 minutes of pre-service time, 15 minutes intra-service time, 6 minutes post-service time, and 26 minutes total time.

Within the family, this service is the lowest complexity study with at least 3-4 channels to review. These 3-4 channels are typically within several hours of data split into 30 second segments and include actigraphy, respiratory tracings, pulse oximetry, and EKG. Therefore, the physician is reviewing multiple points of data and analyzing at least 3-5 parameters that are generated from the data, such as apnea-hypopnea index, arousal index, and periodic limb movement index, while accounting for the clinical history and context.

To support the recommended work RVU, the RUC referenced MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70, 11 minutes intra-service time, and 16 minutes total time) and 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.90, 15 minutes intra-service time, and 22 minutes total time). When compared to the reference codes, the surveyed code is similar in intra-service time and has more total time, although it is less intense/complex to perform, supporting the recommended work RVU.

For additional support, the RUC referenced codes 93888 *Transcranial Doppler study of the intracranial arteries; limited study* (work RVU = 0.73, 15 minutes intra-service time, and 25 minutes total time) and 95983 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional* (work RVU = 0.91, 15 minutes intra-service time, and 28 minutes total time). The surveyed code has identical intra-service time to the reference codes, and the work RVU and total time are appropriately bracketed, supporting the relativity of the recommended work RVU. **The RUC recommends a work RVU of 0.83 for CPT code 95X21.**

95X22 ***Unattended sleep study, interpretation and report by a physician or other qualified health care professional; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories***
The RUC reviewed the survey results from 66 physicians and recommends a work RVU of 1.08, which is lower than the survey 25th percentile work RVU of 1.30, based on a direct crosswalk to CPT code 95822 *Electroencephalogram (EEG); recording in coma or sleep only* (work RVU = 1.08, 18 minutes intra-service time, and 33 minutes total time). The RUC recommends 5 minutes of pre-service time, 18 minutes intra-service time, 8 minutes post-service time, and 31 minutes total time.

Within the family, this service is a moderately complex study with at least 5-10 channels to review. These 5-10 channels are typically within several hours of data split into 30 second segments and include multiple EEG tracings, EMG tracings, respiratory tracings, pulse oximetry, and EKG. Therefore, the physician is reviewing hundreds of points of data and analyzing at least 6-8 parameters that are generated from the data, such as, but not limited to, cardiac indices, apnea-hypopnea index, arousal index, and periodic limb movement index, while accounting for the clinical history and context.

To support the RUC recommended work RVU, the RUC referenced MPC codes 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time, and 26 minutes total time) and 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30, 18 minutes intra-service time, and 27 minutes total time). The reference codes support the recommended work RVU, given the similar intra-service times and more total time required by the surveyed code.

For additional support, the RUC referenced codes 78266 *Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days* (work RVU = 1.08, 20 minutes intra-service time, and 36 minutes total time) and 93975 *Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study* (work RVU = 1.16, 20 minutes intra-service time, and 30 minutes total time). The reference codes support the recommended work RVU given the similar intra-service times and total times to the surveyed code. **The RUC recommends a work RVU of 1.08 for CPT code 95X22.**

95X23 ***Unattended sleep study, interpretation and report by a physician or other qualified health care professional; high complexity of 11 or more channels that generate at least 9 parameter categories***
The RUC reviewed the survey results from 45 physicians and recommends a work RVU of 1.60, which is lower than the survey 25th percentile work RVU of 1.90, based on a direct crosswalk to MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60, 25 minutes intra-service time, and 35 minutes total time). The RUC recommends 9 minutes of pre-service time, 20 minutes intra-service time, 10 minutes post-service time, and 39 minutes total time.

Within the family, this service is the highest complexity study with at least 11 channels to review and interpret. These 11 channels are typically within 7 hours of sleep recorded data split into 30 second segments, and include multiple EEG tracings, EMG tracings, respiratory tracings, pulse oximetry, and EKG. Therefore, the physician is reviewing over 800 points of data and analyzing at least 9 parameters that are generated from the data, such as, but not limited to, cardiac indices, Obstructive Sleep Apnea (OSA) respiratory indices, apnea-hypopnea index, arousal index, and periodic limb movement index, while accounting for the clinical history and context. The patients that receive this

service are typically more complex with several comorbidities that could be contributing to the final diagnoses, increasing the cognitive intensity of the data analysis.

To support the recommended work RVU, the RUC referenced MPC codes 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time, and 32 minutes total time) and 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.75, 20 minutes intra-service time, and 40 minutes total time). The surveyed code has similar intra-service time and total time, although it is slightly less intense/complex to perform and is therefore appropriately valued lower.

For additional support, the RUC referenced code 95813 *Electroencephalogram (EEG) extended monitoring; 61-119 minutes* (work RVU = 1.63, 25 minutes intra-service time, and 35 minutes total time) and MPC code 99221 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.* (work RVU = 1.63, 40 minutes intra-service time, and 40 minutes total time). The surveyed code is supported by the reference codes similar total times and bracketed by the intensity/complexity of the relative services supporting a similar recommended work RVU. **The RUC recommends a work RVU of 1.60 for CPT code 95X23.**

Practice Expense
The Practice Expense (PE) Subcommittee considered and approved compelling evidence based on a change in equipment or practice expense cost and evidence that technology has changed clinical staff time. The new codes were created to capture new devices and new technologies that include varying numbers of leads, channels and parameter categories, and allow for different data capture. This changes the amount of time that technologists spend preparing equipment and educating the patient. As with more channels and/or parameters to review, additional time is required for technical analysis by the clinical staff for some of the new codes. In addition, the PE Subcommittee acknowledged that these services are now used for more than diagnosing obstructive sleep apnea and agreed that there is compelling evidence based on a change in patient population. Accordingly, several changes to the PE equipment and supply inputs are recommended to support the services used to diagnose multiple sleep disorders. **The PE Subcommittee approved compelling evidence based on a change in equipment or practice expense cost and a change in technology impacting clinical staff time, as well as a change in patient population.**

The PE Subcommittee reviewed the direct practice expense inputs for the code family, specifically the three technical component PE-only codes 95X18, 95X19, and 95X20, and made minor modifications. The PE Subcommittee discussed clinical activity CA042 *Perform procedure/service in post-service period---NOT directly related to physician work time* and the specialties provided a breakdown for each of the three codes to describe the first pass (qc review), second pass, technical analysis summary, and cleaning of equipment and wires and repackaging for next use. The Subcommittee also ensured there was no overlap between CA042 and CA024 *Clean room/equipment by clinical staff.*

The PE Subcommittee recommends one new supply item, *Nox A1 Sensor Kit Adult*, for CPT code 95X20. For the equipment inputs, the specialty societies selected only one device for each code. Recognizing that there are 20+ devices available, choosing one was not a majority "typical," rather a "plurality". Each device has its own and very different inputs; some have kits that include items such as tape, others do not have the tape. It is the same concept for batteries, where some are rechargeable, and others are not. The devices below are the basis for the inputs:

- The *Apnea Link Air* device for the low complexity code, 95X18.
- The *Apnea Trak Legacy* device for the moderate complexity code, 95X19.
- The *Nox A1s System with SpO2* for the high complexity code, 95X20.

As noted above, each new recommended equipment item correlates with a specific code and the number of channels derived from the equipment, informing the parameter categories. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

G-Codes
The RUC requests that CMS delete G0398-G0400 for CPT 2027 as they are duplicative with the new CPT codes 95X18, 95X19, 95X20, 95X21, 95X22, and 95X23.

New Technology/New Services
CPT codes 95X18, 95X19, 95X20, 95X21, 95X22, and 95X23 will be placed on the New Technology/New Services list and will be re-reviewed by the RUC in three years.

Autonomic Function Testing (Tab 9)
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In October 2019, the Relativity Assessment Workgroup (RAW) identified CPT code 95923 via the high-volume growth screen, with Medicare utilization of 10,000 or more, which increased by at least 100% from 2013 through 2018. In January 2020, the RAW reviewed the action plan submitted by the specialty societies and the RUC recommended referring codes 95921-95924 to CPT Assistant in 2020 to clarify correct coding on how to report these services. The RAW would review the specialty mix again in three years of those reporting the services (Sept 2023). In September 2023, the specialty societies indicated that the article included correct coding for autonomic testing services when a tilt table was used, clarification on terminology used in the code descriptor language of the code set, and clinical examples for each code. The article intended to reduce miscoding that may be contributing to the total utilization and understand if the shift in dominant specialties is typical. The RAW examined these services and indicated that the decrease in utilization in 2020 may not be attributable to the CPT article, but to due to the COVID-19 pandemic. The RAW noted that these services are typically reported with one another and the code family should be referred to the CPT Editorial Panel to be restructured. In April 2024, the RAW identified code pair 95921/95923 as performed by the same physician on the same date of service 75% of the time or more based on 2022 Medicare Utilization data. The RAW requested action plans for September 2024. In September 2024, the RUC recommended referral to CPT. The specialty societies noted that they submitted a CPT code change application (CCA) for the September 2024 CPT meeting with revisions to the current autonomic function testing code set and the creation of a new Category I code to more accurately reflect current clinical practice and technologies. However, this issue was withdrawn from CPT based on feedback from specialty society comments and CPT Panel reviewers. The specialty societies revised the CCA to address concerns with reported together utilization for the February 2025 CPT meeting. As a result, the CPT Editorial Panel created six new codes to report autonomic function testing with the use of a

tilt table, sudomotor tests, and combined procedures to address the RUC referral. Further, the Panel revised four existing codes to include interpretation and report and clarification on tilt table use. The code family was surveyed for the April 2025 RUC meeting.

Autonomic function tests assess parasympathetic and sympathetic functions of heart rate, blood pressure and sympathetic sweat gland (or sudomotor) control. For purposes of code selection, the tests are essentially in three categories: parasympathetic, sympathetic, and sudomotor. The tests can be performed independently or as a full battery as reflected in the CPT code language.

CPT Code	Parasympathetic (cardiovagal function) including 2 or more of the following: -HR response to deep breathing w/ recorded R-R interval -Valsalva ratio -30:15 ratio	Sympathetic vasomotor function including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and passive tilt ***(includes tilt table in code)***	Sudomotor: QSART or silastic sweat imprint	Sudomotor : thermo-regulatory sweat test	Sudomotor: sympathetic skin response (SSR) potential	*With Tilt Table add-on code (+95XX4)
95921	**X**					*
95922		**X**				
95923			**X**			
95XX5				**X**		
95XX6					**X**	
95924	**X**	**X**				
95XX7	**X**		**X**			*
95XX8		**X**	**X**			
95XX9	**X**	**X**	**X**			

- CPT code 95921 describes testing that evaluates parasympathetic function. A tilt table may be used but is not required and 95XX4 may be reported in addition to this code when a tilt table is used.
- CPT code 95922 describes testing that evaluates sympathetic function. This code does require performance of passive head-up tilt, which must be performed using a tilt table, which is included as indicated in the code descriptor.
    - CPT code 95924 is reported when both the parasympathetic and sympathetic functions, as described in 95921 and 95922 are tested together, and this also requires the use of a tilt table, which is included as indicated in the code descriptor.

The testing of sudomotor function is reported as follows:

- CPT code 95923 describes sudomotor testing that evaluates sweat gland function and should be reported when using the quantitative sudomotor axon reflex test (QSART) or the silastic sweat imprint.
- CPT code 95XX5 describes sudomotor testing, using the thermal regulatory sweat test or TST by recording sweat production and distribution during controlled heating of the entire body.
- CPT code 95XX6 describes evaluation of the sympathetic skin response (SSR) by recording surface electrical responses.

- CPT codes 95XX7, 95XX8 and 95XX9 represent various combinations of tests:
    - CPT code 95XX7 is reported when both the parasympathetic function testing and QSART are performed, a tilt table may be used, but is not required, and add-on code 95XX4 may be reported in addition when a tilt table is used.
    - CPT code 95XX8 is reported when both the sympathetic function tests and QSART are performed and require the use of a tilt table, as indicated in the code descriptor.
    - CPT code 95XX9 is reported when parasympathetic, sympathetic, and QSART testing are performed. CPT code 95XX9 also requires the use of a tilt table as indicated in the code descriptor.

The autonomic function testing codes require interpretation and report by a physician or other qualified health care provider (QHP) and should not be used for tests that include algorithmically aided diagnostic support tools. The CPT Editorial Panel added this language to eliminate potential misuse when the appropriate physician work is not performed and eliminate the potential for reporting with automated devices**.**

Compelling Evidence
The specialty societies presented compelling evidence to consider an increase in the value for CPT code family 95921-95XX9, specifically that there has been a change in physician work due to changes in technique and knowledge/technology to perform these services. For Valsalva responses as part of sympathetic testing, additional quantitative analyses are now typical. In addition to the "classic" elements included at the time of the last survey; additional analyses including pressure time recovery (PRT), sympathetic index (SI), and baroreflex sensitivity (BRS) are now typical. These have increased the cognitive complexity, time, and effort required to interpret Valsalva testing. This change is reflected in the updated description of physician work, which now details visualization of physiological data (including determination of wave form morphology, sources of artifact, and quantitative analysis) and correlation of available clinical data with test results. For codes where interpretation is required for a combination of multiple test procedures (e.g., 95XX7, 95XX8, 95XX9, which includes combinations of sudomotor, sympathetic and parasympathetic testing the integration of multiple modality data is required. These newly implemented analyses add complexity and intensity to the physician work.

In the past 10 years, there has been enhanced knowledge in epidemiology, etiology, pathophysiology, genetics, diagnostic criteria, differential diagnoses, and management of discrete autonomic disorders that in the past were grouped together as "dysautonomia". The specialty societies indicated that enhanced knowledge in a disease or group of diseases results in proper and targeted utilization of relevant diagnostic procedures and further adds to the complexity of physician work.

In addition to this change in physician work, utilization is expected to significantly decrease for at least a portion of the existing code set and shifts in dominant specialties, particularly for existing code 95923, which previously encompassed multiple, technically differing procedures. These procedures are now described under individual codes (95923, 95XX5 and 95XX6); it is expected that these coding changes will reduce any existing misuse of the codes, as well as result in a shift in use toward the dominant specialty, neurology. **The RUC agreed that there is compelling evidence that there has been a change in physician work due to changes in technique and knowledge/technology to perform these services.**

95921 ***Testing of autonomic nervous system function, with interpretation and report; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio***

The RUC reviewed the survey results from 54 neurologists and internal medicine physicians and determined the survey 25th percentile work RVU of 0.90, which is also the current value, appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-service time, 15 minutes intra-service and 5 minutes post-service time, totaling 25 minutes. The RUC reduced the post-service time from 10 to 5 minutes. The RUC noted that this service is typically reported with an office Evaluation and Management (E/M) service and ensured there is no duplication in pre- or post-service work. The 5 minutes of pre-service time account for evaluating the patient characteristics relative to the data to be collected, the appropriateness of the test for the patient and whether the patient is prepared for it in a way that will result in valid data. The post-service time of 5 minutes accounts for the physician and interpretation of the raw data that they visualized and marked during performing the test, which is performed for separate indications clinically and diagnostically than the E/M.

CPT code 95921 describes testing which evaluates parasympathetic (cardiovagal) function and includes electrocardiographic monitoring of heart rate derived from the variability in time elapsing between two consecutive R waves in the electrocardiogram. A tilt table may be used, but it is not required for testing parasympathetic function. CPT code 95XX4 may be reported in addition to 95921 when a tilt table is used to perform the tests.

The RUC compared the surveyed code to the top key reference code 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00, 15 minutes intra-service time and 35 minutes total time) and determined that the surveyed code requires less pre- and post-service time and slightly less physician work, thus is appropriately valued lower. The survey respondents that selected this key reference indicated that the surveyed code is identical or somewhat more intense than key reference code 95907. The RUC compared the surveyed code to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30, 20 minutes intra-service and 30 minutes total time) and determined that the surveyed code requires slightly less physician work and intra-service time to perform, thus is appropriately valued lower.

For additional support the RUC referenced MPC codes 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time and 26 minutes total time), which clinically is a similar testing code. CPT code 93015 is less intense and complex compared to the surveyed code, with five minutes more intra-service time, which is less intense during the service period. The RUC also compared the surveyed code to MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time), which is slightly more intense and complex than the surveyed code. Both MPC codes bracket the surveyed code and are comparable for physician work and time. The RUC determined that the survey 25th percentile work RVU of 0.90 appropriately places CPT code 95921 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.90 for CPT code 95921.**

95XX4 ***Testing of autonomic nervous system function, with interpretation and report; use of tilt table (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 neurologists and determined a work RVU of 0.35 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of intra-service and total time. The RUC agreed with the specialty societies and recommends a direct crosswalk to the top key reference service, CPT code 95885 *Needle electromyography, each*

extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure) (work RVU = 0.35, 15 minutes intra-service and total time). These services both require the same amount of physician time and work to perform.

CPT code 95XX4 may be reported in addition to 95921 and 95XX7 when a tilt table is used to perform these tests. Mental effort and clinical judgment are required for the physician to deem that the typical use of 95921 and 95XX7 without a tilt table is not sufficient to make a diagnosis. Then the physician must confer and make sure that the tilt table is necessary as part of the physician work, and then also interpret the results with the tilt table, which is more data in addition to that was also already gathered in the base codes.

The RUC compared the surveyed code to the top key reference service 95886 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure*) (work RVU = 0.86, 30 minutes intra-service and total time) and determined that the surveyed code requires less physician work and time to perform, thus is appropriately valued lower.

For additional support the RUC referenced MPC codes 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure*) (work RVU = 0.19, 5 minutes intra-service time and 6 minutes total time). The surveyed code requires more physician work and time than 96367, thus is appropriately valued higher. The RUC also compared the surveyed code to MPC code 77002 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure*) (work RVU = 0.54, 15 minutes intra-service time and 17 minutes total time), which requires more work and intensity to perform than the surveyed code. Both MPC codes bracket the surveyed code and are comparable for physician work and time. The RUC determined a work RVU of 0.35 appropriately places CPT code 95XX4 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.35 for CPT code 95XX4.**

95922 ***Testing of autonomic nervous system function, with interpretation and report; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt (ie, tilt table)***

The RUC reviewed the survey results from 46 neurologists and internal medicine physicians and determined that the current work RVU of 0.96, which is below the survey 25th percentile work RVU of 1.02, appropriately accounts for the work required to perform this service. The RUC recommends 6 minutes pre-service time, 20 minutes intra-service and 10 minutes post-service time, totaling 36 minutes. The RUC noted that this
service is typically reported with an office Evaluation and Management (E/M) service and ensured there is no duplication in pre- or post-service work. For code 95922, there are multiple additional sources of data and types of analyses performed that make the assembly of the report more complex and more detailed and extensive.

CPT code 95922 describes testing that evaluates sympathetic effects on heart rate and blood pressure control. Code 95922 requires continuous recording of beat-to-beat blood pressure and heart rate, a period of supine rest of at least 20 minutes prior to testing, a minimum of two (2) Valsalva maneuvers, and the performance of passive head-up tilt, which must be performed using a tilt table.

The RUC compared the surveyed code to the top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30, 20 minutes intra-service and 30 minutes total time) and determined that the surveyed code requires the same intra-service time but less intense and requires slightly less physician work, thus is appropriately valued lower. The RUC compared the surveyed code to the second top key reference code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time), and determined that the surveyed code requires slightly more time to perform but requires nearly the same overall intensity and complexity to perform as code 95819, with 67 percent of survey respondents who chose this as a key reference service indicating as such. Thus, the surveyed code is valued similarly relative to code 95819.

For additional support the RUC referenced MPC code 95971 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RVU = 0.78, 20 minutes intra-service time and 33 minutes total time). The surveyed code requires more physician work and is more intense and complex to perform, thus valued higher than code 95971. The RUC determined that the current work RVU of 0.96 appropriately places CPT code 95922 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.96 for CPT code 95922.**

95923 ***Testing of autonomic nervous system function, with interpretation and report; sudomotor, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint***
The RUC reviewed the survey results from 52 neurologists and internal medicine physicians and determined the current work RVU of 0.90, which is below the survey 25th percentile work RVU of 1.00, appropriately accounts for the work required to perform this service. The RUC recommends 8 minutes pre-service time, 15 minutes intra-service and 9 minutes post-service time, totaling 32 minutes. The RUC noted that this service is typically reported with an office Evaluation and Management (E/M) service and ensured there is no duplication in pre- or post-service work.

CPT code 95923 describes testing that evaluates sweat gland (sudomotor) function. Code 95923 should be reported only when performing quantitative evaluation of sweat gland function using the quantitative sudomotor axon reflex test (QSART) or the silastic sweat imprint test. Previously, QSART, thermoregulatory sweat test (TST) and sympathetic skin response (SSR) testing were all reported with CPT code 95923. The revised coding structure established a unique CPT code for each test. At the time the code was last reviewed, QSART was the most typical test to evaluate sudomotor function and the code was valued based on the work associated with the QSART.

The RUC compared the surveyed code to the top key reference code 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00, 15 minutes intra-service time and 35 minutes total time) and determined these services require the same intra-service time, with the surveyed code requiring slightly less total time to perform, thus are valued slightly lower. The RUC compared the surveyed code to the second top key reference service 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54, 29 minutes intra-service and 49 minutes total time) and determined that the surveyed code requires less physician work and time to perform, thus is appropriately valued lower.

For additional support, the RUC referenced MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time). The surveyed code requires more physician work and time to perform compared to 99212, thus is valued higher. The RUC determined that the current work RVU of 0.90 appropriately places CPT code 95923 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.90 for CPT code 95923.**

95XX5 ***Testing of autonomic nervous system function, with interpretation and report; sudomotor, thermoregulatory sweat test***

The RUC reviewed the survey results from 31 neurologists and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service time, 20 minutes intra-service and 10 minutes post-service time, totaling 40 minutes. CPT code 95XX5 is the most difficult to perform out of the sudomotor tests, therefore, 5 minutes more of intra-service time compared to CPT code 95923 is appropriate. The QSART test (95923) focuses on peripheral nerves, whereas in this case, 95XX5 focuses on central nervous system sweat control, and requires additional data analysis and considerations in terms of the physician's clinical review.

CPT code 95XX5 describes testing that evaluates sudomotor function using the thermoregulatory sweat test (TST) by recording sweat production and distribution during controlled heating of the whole body. Previously all sudomotor testing including quantitative sudomotor axon reflex test (QSART), thermoregulatory sweat test (TST), and sympathetic skin response (SSR) testing were all reported with CPT code 95923. At the time the code was last reviewed, QSART was the most typical test to evaluate sudomotor function and the code was valued based on the work associated with the QSART. The revised coding structure established a unique CPT code for each test.

The RUC questioned whether 95XX5 will typically be reported with any other codes in this family. The specialty societies indicated that 95XX5 is only available at very few institutions across the country and is such a tiny fraction, probably less than 1%, of the sudomotor tests that are performed. Therefore, it will be rare that 95XX5 will be reported with other codes in this family.

The RUC compared the surveyed code to the top key reference code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time), and determined that the surveyed code requires more time to perform but requires nearly identical overall intensity and complexity to perform as code 95819, with 60 percent of survey respondents who chose this as a key reference service indicating as such. Thus, the surveyed code and 95819 are valued similarly. The RUC compared the surveyed code to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a*

medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded (work RVU = 1.30, 20 minutes intra-service and 30 minutes total time) and determined that the surveyed code requires the same intra-service time but less intense and requires slightly less physician work, thus is appropriately valued lower.

For additional support the RUC referenced MPC codes 95971 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RVU = 0.78, 20 minutes intra-service time and 33 minutes total time). The surveyed code requires more physician work and is more intense and complex to perform, thus valued higher than code 95971. The RUC also compared the surveyed code to MPC code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.75, 20 minutes intra-service time and 40 minutes total time), which requires more work and intensity to perform than the surveyed code. Both MPC codes bracket the surveyed code and are comparable for physician work and time. The RUC determined that the survey 25th percentile work RVU of 1.00 appropriately places CPT code 95XX5 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 1.00 for CPT code 95XX5.**

95XX6 *Testing of autonomic nervous system function, with interpretation and report; sudomotor, assessing the sympathetic skin response (SSR) potential*

The RUC reviewed the survey results from 35 neurologists and determined the survey 25th percentile work RVU of 0.50 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service and 5 minutes post-service time, totaling 20 minutes. The specialty societies noted that this service is not expected to typically be reported with an office Evaluation and Management (E/M) service because it is performed separately in the electromyography (EMG) lab.

CPT code 95XX6 describes testing that evaluates the sympathetic skin response (SSR) by recording surface electrical responses from the palmar or plantar surfaces after electrical stimulation of a nerve trunk of the limb being tested. Previously all sudomotor testing including quantitative sudomotor axon reflex test (QSART), thermoregulatory sweat test (TST), and SSR testing were all reported with CPT code 95923. At the time the code was last reviewed, QSART was the most typical test to evaluate sudomotor function and the code was valued based on the work associated with the QSART. The revised coding structure established a unique CPT code for each test.

The RUC compared the surveyed code to the top key reference code 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00, 15 minutes intra-service time and 35 minutes total time) and determined that the surveyed code requires significantly less physician time and work, thus is valued have that of 95907. The RUC compared the surveyed code to the second top key reference service 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.39, 8 minutes intra-service and 15 minutes total time) and

determined that the surveyed code requires slightly more physician time and work, thus is appropriately valued higher.

For additional support, the RUC referenced MPC code 76830 *Ultrasound, transvaginal* (work RVU = 0.69, 10 minutes intra-service time and 23 minutes total time). The surveyed code requires slightly less physician work and time to perform compared to 76830, thus is valued lower. The RUC determined that the survey 25th percentile work RVU of 0.50 appropriately places CPT code 95XX6 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.50 for CPT code 95XX6.**

95924 ***Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt (ie, tilt table)***

The RUC reviewed the survey results from 50 neurologists and internal medicine physicians and determined the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service time, 25 minutes intra-service and 12 minutes post-service time, totaling 47 minutes. The RUC noted that this service is typically reported with an office Evaluation and Management (E/M) service and ensured there is no duplication in pre- or post-service work.

CPT code 95924 is reported when both the parasympathetic (cardiovagal) function and the sympathetic adrenergic function as described in CPT codes 95921 and 95922 are tested together with the use of a tilt table.

The intensity for CPT code 95924 is now much higher than 95921 and 95922. The specialty societies indicated, and the RUC agreed that this is appropriate because there is the added complexity as outlined in 95922 from current and the interpretation of both the sympathetic and parasympathetic systems data and then the integration of that into one cohesive interpretation.

The RUC compared the surveyed code to the top key reference code 95717 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without videos* (work RVU = 2.00, 28 minutes intra-service time and 46 minutes total time) and determined that these services require almost identical time, however the surveyed code is slightly less intense and complex to perform, thus valued lower.

The RUC compared the surveyed code to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.92, 30 minutes intra-service and 47 minutes total time) and determined that the surveyed code requires and determined that these services require almost identical total time, however the surveyed code is slightly less intense and complex to perform.

For additional support, the RUC referenced MPC codes 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time and 26 minutes total time). CPT code 93015 is less intense and complex compared to the surveyed code and requires less physician work and time to perform. The RUC also compared the surveyed code to MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54, 29 minutes intra-service time and 49 minutes

total time), which is slightly more intense and complex, and requires more physician work and time than the surveyed code. Both MPC codes bracket the surveyed code and are comparable for physician work and time. The RUC determined that the survey 25th percentile work RVU of 1.50 appropriately places CPT code 95924 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 1.50 for CPT code 95924.**

95XX7 ***Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint***

CPT code 95XX7 describes testing when both the parasympathetic (cardiovagal) function and sweat gland function (sudomotor) QSART evaluation are performed. A tilt table may be used but is not required for testing parasympathetic function. Code 95XX4 may be reported in addition to 95XX7 when a tilt table is used to perform the tests.

The RUC reviewed the survey results from 34 neurologists and determined a work RVU of 1.20 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service time, 20 minutes intra-service and 10 minutes post-service time, totaling 40 minutes. The specialty societies indicated, and the RUC agreed that the survey 25th percentile work RVU of 1.02 would create a rank order anomaly as it would result in a lower intensity than 95923, when the QSART test is performed alone. The RUC recommends a direct crosswalk to CPT code 76988 *Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only* (work RVU = 1.20, 20 minutes intra-service time and 35 minutes total time).

The RUC compared the surveyed code to the top key reference service 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54, 29 minutes intra-service and 49 minutes total time) and determined that the surveyed code requires less physician work and time to perform, thus is appropriately valued lower. The RUC compared the surveyed code to the second top key reference code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time), and determined that the surveyed code requires more time, thus is appropriately valued higher.

For additional support the RUC referenced MPC code 95971 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RVU = 0.78, 20 minutes intra-service time and 33 minutes total time). The surveyed code requires more physician work and is more intense and complex to perform, thus valued higher than code 95971. The RUC also referenced CPT code 95868 *Needle electromyography; cranial nerve supplied muscles, bilateral* (work RVU = 1.18, 20 minutes intra-service time and 40 minutes total time), which requires the same physician time and nearly identical work to perform. The RUC determined that the work RVU of 1.20 appropriately places CPT code 95XX7 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 1.20 for CPT code 95XX7.**

95XX8 ***Testing of autonomic nervous system function, with interpretation and report; combined sympathetic adrenergic with at least 5 minutes of passive tilt (ie, tilt table) and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint***
The RUC reviewed the survey results from 32 neurologists and determined the survey median work RVU of 1.75 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service time, 30 minutes intra-service and 10 minutes post-service time, totaling 50 minutes. The specialty societies noted, and the RUC agreed, that the 25th percentile work RVU of 1.50 would create a rank order anomaly as it would result in a lower intensity than 95923 when the QSART test is performed alone. These combined tests are more complex, due to the interpreting physician needing to integrate more data points into a cohesive interpretation.

CPT code 95XX8 describes when both the sympathetic function and sweat gland (sudomotor) function evaluation QSART are performed. CPT code 95XX8 requires the use of a tilt table.

The RUC compared the surveyed code to the top key reference code 95717 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without videos* (work RVU = 2.00, 28 minutes intra-service time and 46 minutes total time) and determined the surveyed service requires more time but is slightly less intense and complex to perform. The RUC compared the surveyed code to the second top key reference service 95813 *Electroencephalogram (EEG) extended monitoring; 61-119 minutes* (work RVU = 1.63, 25 minutes intra-service and 35 minutes total time) and determined that the surveyed code requires more physician time and work to perform, thus appropriately valued higher.

For additional support, the RUC referenced MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time), which is slightly more intense and complex, and requires more physician work and time than the surveyed code. The RUC determined that the survey median work RVU of 1.75 appropriately places CPT code 95XX8 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 1.75 for CPT code 95XX8.**

95XX9 ***Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic, sympathetic adrenergic function with at least 5 minutes of passive tilt (ie, tilt table), and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint***
The RUC reviewed the survey results from 35 neurologists and determined the survey 25th percentile work RVU of 1.91 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service time, 30 minutes intra-service and 12 minutes post-service time, totaling 52 minutes.

CPT code 95XX9 describes when both the parasympathetic (cardiovagal) function, sympathetic function and sweat gland (sudomotor) function QSART are performed. CPT code 95XX9 requires the use of a tilt table. CPT code 95XX9 is reported when all three major tests are performed together, therefore it is the most complex and time intensive of the family.

The RUC compared the surveyed code to the top key reference service 99239 *Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter* (work RVU = 2.15, 45 minutes intra-service and 64 minutes total time) and determined that the surveyed code

requires less physician time and work, thus appropriately valued lower. The RUC compared the surveyed code to the second top key reference code 95717 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without videos* (work RVU = 2.00, 28 minutes intra-service time and 46 minutes total time) and determined the surveyed service requires slightly more time, but is slightly less intense and complex to perform, thus appropriately valued lower.

For additional support, the RUC referenced MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.92, 30 minutes intra-service time and 47
minutes total time), which requires similar physician work and time to perform. The RUC determined that the survey 25th percentile work RVU of 1.91 appropriately places CPT code 95XX9 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 1.91 for CPT code 95XX9.**

RUC Referral to CPT
The RUC expressed concern about the possible reporting of some of these services together, thus resulting in duplication of work. **Upon the conclusion of the RUC meeting, the specialty societies submitted a letter to the CPT Editorial Panel requesting to add CPT code 95XX5 to the parenthetical instructions for codes 95921, 95922, 95923, 95XX6, 95924, 95XX7, 95XX8, 95XX9:**

(Do not report 95921 in conjunction with 95922, 95923, 95XX5, 95XX6, 95924, 95XX7, 95XX8, 95XX9)
(Do not report 95922 in conjunction with 95921, 95923, 95XX5, 95XX6, 95924, 95XX7, 95XX8, 95XX9)
(Do not report 95923 in conjunction with 95921, 95922, 95XX5, 95XX6, 95924, 95XX7, 95XX8, 95XX9)
(Do not report 95924 in conjunction with 95921, 95922, 95923, 95XX5, 95XX6, 95XX7, 95XX8, 95XX9)
(Do not report 95XX6 in conjunction with 95921, 95922, 95923, 95XX5, 95924, 95XX7, 95XX8, 95XX9)
(Do not report 95XX7 in conjunction with 95921, 95922, 95923, 95XX5, 95XX6, 95924, 95XX8, 95XX9)
(Do not report 95XX8 in conjunction with 95921, 95922, 95923, 95XX5, 95XX6, 95924, 95XX7, 95XX9)
(Do not report 95XX9 in conjunction with 95921, 95922, 95923, 95XX5, 95XX6, 95924, 95XX7, 95XX8)

Practice Expense
The Practice Expense (PE) Subcommittee considered and approved compelling evidence based on a change in specialty, as the dominant provider for the six new codes is expected to be Neurology, and there is a change in the way the procedures are performed using additional and updated supplies. The following supplies were added: 4 SC052 *syringe 1 ml*, 1 SC029 *needle, 18-27g* and 1 SB022 *gloves, non-sterile,* for the testing codes 95923, 95XX7, 95XX8 and 95XX9, which employ SH002 *acetylcholine*. Invoices were submitted for three new supplies: *Filtered Mouthpiece, Gel Trode 2x2 Return Electrode* and *Meridian Electrode w/Expanding Foam*. The specialty societies explained the four codes that include QSART testing (95923, 95XX7, 95XX8 and 95XX9) require the use of SG055 *gauze, sterile 4in x 4in* to ensure the recording site is fully dry per protocol, rather than air-drying, while

the gauze was removed from those codes which do not require patting dry the recording site (95921, 95922, 95XX6, 95924). Clarification was also provided on the tilt table and that it is only indicated in the services in which it is utilized (codes 95922, 95924, 95XX4, 95XX8 and 95XX9). Lastly, the PE Subcommittee ensured that the clinical activities were not duplicative of Evaluation and Management (E/M) services and justified the use of CA005 *Complete pre-procedure phone calls and prescription* for all the XXX codes in the family. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Reported with E/M
The RUC noted that the 2023 Medicare data showed that the existing codes 95921, 95922, 95923 and 95924 were typically reported with an E/M 51%-53% of the time. The specialty societies noted that a large part of the reason for this code family restructuring was because there was most likely still inappropriate reporting of these services by the wrong specialty and without the use of a tilt table. The RUC noted that it is possible that those inappropriately reporting these services were also the same individuals reporting with an E/M office visit on the same day. These services are expected to be primarily reported by neurology and not with an E/M on the same day. The RUC confirmed that it will analyze these services to ensure that the new coding structure is being reported as predicted when it reviews all CPT 2027 codes utilization data when available.

Laser Treatment for Psoriasis (Tab 10)
Mark Kaufmann, MD (AADA), Howard Rogers, MD (AADA)

In October 2015, CPT codes 96920, 96921 and 96922 were identified via the high-volume growth screen with Medicare utilization of 10,000 or more that increased by at least 100% from 2008 through 2013. At that time, the RUC recommended that the specialty societies develop a CPT Assistant article to ensure the codes were being used correctly, which was published in September 2016. This was the third article created for this code set, with articles also published in June 2012 and May 2013.

In January 2022, the Relativity Assessment Workgroup (RAW) reviewed these services again, noting that their utilization continued to steadily increase, specifically CPT code 96920. Use of 96920 peaked at 117,256 in 2016, dropped to 79,671 in 2020, and increased to 88,673 in 2021. The specialty societies indicated that they believed the growth is appropriate due to changes in treatment and medication for psoriasis. However, due to the continued growth, the RAW recommended, and the RUC agreed, that CPT codes 96920, 96921 and 96922 be surveyed for work and practice expense at the April 2022 RUC meeting.

In April 2022, CPT codes 96920-96922 were referred to the CPT Editorial Panel for editorial review. Since the CPT descriptor was established in 2002, psoriasis was the only approved indication and use for this treatment modality. The specialty societies stated the indications had expanded beyond those noted in the code descriptors to include laser treatment for other inflammatory skin disorders. At the September 2022 CPT meeting, the tab was withdrawn when it was determined that the specialties' proposed changes were beyond editorial. This issue was deferred to the February 2023 CPT meeting and subsequently withdrawn as it was determined that existing literature was insufficient and did not support expanded indications at that time.

The presenters described the recent history of this code set and its route back to the RUC. This issue was surveyed for the April 2023 RUC meeting, without any revisions to the code descriptors, since the available 2021 Medicare data indicated that the typical patient was being treated for psoriasis (96920, psoriasis = 79.3%). At the April 2023 meeting, the RUC voted to recommend an editorial change to CPT to add "(ie, excimer)" after "Laser treatment" for clarity in codes 96920-96922. The codes were also flagged as "Do Not Use to Validate for Physician Work" as the times were not

representative. At the May 2023 CPT Editorial Panel meeting, the CPT Executive Committee voted to editorially revise the code family parent code 96920 to align with the intended use of these services exclusively for psoriasis using an "Excimer" laser. These editorial revisions for the CPT 2024 code set did not involve a change in physician work. However, despite a CPT Assistant article, concern resulted from the addition of the term "excimer" to the descriptor for those using other types of appropriate ultraviolet lasers. Subsequently, at the February 2025 CPT Editorial Panel meeting, the codes were further revised to remove "Excimer" from the code descriptor and specify the wavelengths for other lasers that treat psoriasis that are not excimer lasers.

In preparation for the April 2025 RUC meeting, the specialty society submitted a letter to the RUC that detailed the revisions to the code family (removing "excimer" and specifying a wavelength range for treatment "308-312 nanometers") and stated that the specialty considers these updates editorial in nature. The typical patient, typical laser equipment, typical treatment procedure, and its associated work are unchanged. The specialty explained that an excimer laser delivers UV light energy within the range specified by the revised code descriptors and, while it is not the only laser that may be used in the phototherapy treatment of psoriasis, it is still the typical device. The excimer laser is the dominant laser with about 85% share of the ultraviolet lasers currently in use.

The specialty society also acknowledged that the code family will return to the CPT Editorial Panel in May 2025 with a new code change application (CCA) proposing to expand the laser codes beyond the treatment of psoriasis to include other inflammatory skin disorders. If approved by the CPT Editorial Panel, a RUC survey will be required to evaluate physician work and practice expense for any expanded indications. For these reasons, the specialty society requested that the RUC affirm the current values and CMS inputs for CPT codes 96920-96922.

Upon consideration at the April 2025 RUC meeting, the RUC concurred that the code descriptor changes since the laser codes were last reviewed in 2023 are editorial in nature. Furthermore, a new CCA is being considered by the CPT Editorial Panel with expanded indications that will require a RUC survey. In addition, it was noted that the codes are included in the "Do not use to validate physician work" screen that will also require resurvey for the September 2025 RUC meeting.

The RUC agreed with the specialty society's request to affirm the current CMS values for CPT codes 96920, 96921 and 96922. **The RUC concurs that the current CMS values be maintained and therefore recommends a work RVU of 0.83 for CPT code 96920, 0.90 for CPT code 96921, and 1.15 for CPT code 96922.**

Practice Expense

The specialty society requested that the Practice Expense (PE) Subcommittee affirm the current CMS inputs for CPT codes 96920, 96921 and 96922 as the code descriptor revisions do not change the current work or PE inputs. The American Academy of Dermatology Association confirmed that the excimer laser remains the typical equipment used for the code family. It was acknowledged that CMS did not accept the change in business model for excimer lasers to a per-use rental (subscription model), as recommended at the April 2023 RUC meeting, since the equipment item EQ161 *laser, excimer* is available for purchase and already accounted for under its equipment methodology. The PE Subcommittee agreed to maintain the direct practice inputs without modification. **The RUC recommends the current CMS direct practice expense inputs be maintained as affirmed by the Practice Expense Subcommittee.**

VIII. CMS Request/Relativity Assessment Identified Codes

<u>Stereotactic Computer-Assisted Volumetric Navigational Procedures (Tab 11)</u>
Brian Boyce, MD (AAO-HNS), William Lavelle, MD (ISASS), Peter Manes, MD (AAO-HNS), Clemens Schirmer, MD (AANS/CNS), Karin Swarz, MD (NASS)

In April 2024, CPT code 61783 was identified by the Relativity Assessment Workgroup (RAW) via the high-volume growth screen, with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. In January 2025, the RAW reviewed the action plan for CPT code 61783 and determined that this service was last valued in 2010, and utilization is steadily increasing, thus should be surveyed with the appropriate family of codes for April 2025.

In October 2008, CPT code 61795 *Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal* (2008 work RVU = 4.03) was identified for potential misvaluation through the CMS Fastest Growing Screen. The RUC and the specialty societies determined that the work and technology related to intracranial, extracranial and spinal procedures may be different. Thus, the specialty societies submitted a code change application to the CPT Editorial Panel. At the October 2009 CPT Editorial Panel meeting, CPT code 61795 was deleted, and three new codes (61781, 61782 and 61783) were created to separately report cranial intradural, cranial extradural and spinal stereotactic computer-assisted volumetric procedures respectively. CPT codes 61781, 61782 and 61783 were reviewed at the February 2010 RUC meeting for publication in CPT 2011. CPT codes 61781 and 61783 were valued the same at 3.75 work RVUs and 61782 was valued at 3.18 work RVUs.

Based on 2023 Medicare utilization, CPT code 61781 is performed by neurosurgery (97%), CPT code 61783 is performed by neurosurgery (67%) and orthopaedic surgery (32%) and 61782 is performed by otolaryngology (98%). No specialty society interest was submitted to survey code 61781, and there is no recommendation. Otolaryngology surveyed code 61782 and neurosurgery, orthopaedic surgery and spine surgery surveyed code 61783.

Family of Services
The specialty societies indicated that CPT codes 61781, 61782 and 61783 are not a family of services as they are reported with distinctly different procedures and should not have been placed for convenience together in the Nervous System/ Skull, Meninges, and Brain/Stereotaxis subsection of CPT. The specialty societies believe that it was not correct to maintain all three codes together in the Nervous System section as established. Specifically, there is a Spine and Spinal Column/Stereotaxis subsection under the Nervous System subsection where code 61783 could have been located, or it could also have been placed in the Musculoskeletal System/Spine subsection. The specialty societies also question whether 61782 is correctly placed in the Nervous System section instead of in the Musculoskeletal System/Head subsection, closer to the procedures that 61782 is typically reported.

The RUC noted that these three services were valued together initially and the valuation for codes 61781 and 61783 is the same and is based on the same methodology. The RUC is concerned that a possible rank order anomaly may occur if valued separately. **The RUC disagrees with the specialty societies and recommends that 61781 be surveyed with 61782 and 61783 for September 2025.**

***ZZZ* Survey Template**
CPT codes 61781, 61782 and 61783 were all surveyed for pre- and post-service time in 2010, and each included 15 minutes of pre-service time. CPT codes 61782 and 61783 were surveyed this time with the standard ZZZ survey template, which specifies the ZZZ global period as a *code related to another service and is always included in the global period of the other service (Note: Physician*

work is associated with intra-service time and in some instances the pre-and post-service time) and only asks for the day of procedure intra-service time. In rare circumstances, specialties may provide justification and request that a ZZZ survey with pre- and post-service time be conducted. The specialty societies are requesting to resurvey these services with the pre/post ZZZ survey template.

The specialties indicated that they believe the pre-service time that was captured in the 2010 valuation remains an integral part of this work for these services. Pre-service time is essential and inseparable from these services. For CPT code 61782, this work includes critical, physician-performed tasks directly related to the implementation and use of stereotactic computer navigation. These include an in-depth discussion with the patient about the rationale for the navigation system, its role in enhancing surgical precision, and its implications for surgical complexity and duration. This is particularly relevant in cases involving altered anatomy or proximity to critical structures. In addition, the surgeon must initiate, configure, and verify the navigation system, including hardware setup, image review in multiple planes, software validation, and procedural planning based on the individual patient's anatomy and pathology. These are non-delegable, case-specific activities that are essential to the safe and effective use of this advanced technology and therefore justify discrete pre-service time beyond what is included in the base code.

For 61783, this work includes critical, physician-only tasks that cannot be delegated, such as consulting with the patient about the placement of an additional tracker for spinal navigation, segmenting spinal levels, planning pedicle trajectories, and positioning the navigation system, all of which are fundamental to the success of the procedure and must be completed before sterile draping.

The RUC determined that the specialty societies may survey 61781, 61782 and 61783 with the amended ZZZ survey template that specifically asks the respondent whether pre- and post-service time is associated with these add-on services.

61781 ***Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)***
No specialty society interest was submitted to survey code 61781, and there is no recommendation. **No RUC recommendation is submitted for CPT code 61781. The RUC recommends 61781 be surveyed with 61782 and 61783 for September 2025.**

61782 ***Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 141 otolaryngologists and determined that the survey 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service based on the current survey. The RUC recommends interim times of 0 minutes pre-service time and 20 minutes intra-service time, totaling 20 minutes. The specialty societies did not survey for pre-service time and have requested to resurvey with an amended survey instrument, specifically asking if separate pre-service time from the base code occurs for this service. The RUC recommends an interim work RVU of 2.50 and resurvey for September 2025.

The RUC compared the surveyed code to the top key reference code 19294 *Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)* (work RVU = 3.00, 40 minutes intra-service time and total time) and determined the surveyed code requires much less physician work and time and thus is appropriately valued lower. The RUC noted that if the surveyed code had pre-time, code 19294 is a comparable service.

For additional support, the RUC referenced code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU = 2.50, 25 minutes intra-service time and 32 minutes total time), which requires more time, but the surveyed code is somewhat more intense and complex to perform. **The RUC recommends an interim work RVU of 2.50 for CPT code 61782 and resurvey with the pre/post time ZZZ survey template for review at the September 2025 RUC meeting.**

61783 ***Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 146 neurosurgeons, orthopaedic surgeons and spine surgeons, and determined the survey 25th percentile work RVU of 3.50 and 30 minutes of intra-service and total time are appropriate based on the current survey. The specialty societies requested to resurvey CPT code 61783, using the specific ZZZ survey template with pre/post-service time.

The RUC compared the surveyed code to the second top key reference service 61797 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)* (work RVU = 3.48, 30 minutes intra-service and total time) and determined that the these services both require the same physician work and time, thus are valued similarly.

For additional support the RUC referenced code 67335 *Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)* (work RVU = 3.23, 30 minutes intra-service time and total time), which requires similar physician work and time. **The RUC recommends an interim value of 3.50 for CPT code 61783 and resurvey with the pre/post time ZZZ survey template for review at the September 2025 RUC meeting.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for CPT code 61782 and made a single modification. Invoices were submitted for three new supplies: *single use instrumentation wire, patient tracker* and *adhesive pad*. The Subcommittee amended the patient tracker inputs to correct the price of the new supply item since it is available in a 5-pack, and the adhesive in a 10-pack, but only one of each is used. The specialty societies also recommended four new equipment items: *navigation system, pointer shell universal mounts, medical cart without monitor* and *registration pointer*. The RUC noted the equipment *service contract standard* was not included because maintenance such as a service contract is already included in the calculation of the cost per minute. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

IX. Research Subcommittee (Tab 12)

Doctor Thomas Weida, Chair, provided the report of the Research Subcommittee.

- **Review of February 24th and March 13th Research Subcommittee Conference Call Reports**
  The Research Subcommittee reports from the February 24th and March 13th conference calls included in Tab 12 agenda materials were approved without modification.

- **Standard RUC Survey**
  On the March 13th Research Subcommittee conference call, AMA staff demonstrated the RUC online survey tool to the Research Subcommittee. The Subcommittee was solicited for feedback at that time and the following issues were identified for discussion at the April 2025 in-person meeting.

  - **Full CPT Language Review Attestation**
    Several Subcommittee members had suggested that an attestation question should be incorporated into the standard RUC survey template, requiring respondents to confirm their review of the full CPT guidelines. Currently this question is added on a case-by-case basis. For example, all of the recent E/M surveys had this question included.

    The Subcommittee considered this issue during the April 2025 meeting and determined to maintain the current process without modification. Currently, the RUC requires RUC surveys to include the full CPT language for each survey code under review, including CPT introductory guidelines, long descriptors and parentheticals. An CPT guideline review attestation question can be added by societies on a case-by-case basis.

  - **Practice Demographic Question Review**
    A Subcommittee member had inquired whether the urban/rural/suburban and single specialty/ multispecialty practice setting questions should be retained. A proposal was made to consider the elimination of these questions. During the April 2025 discussion, Subcommittee members concurred that it would be appropriate to delete these questions for all standard RUC survey templates in order to reduce survey fatigue. Also, Subcommittee members noted that these data are not currently summarized in the RUC summary of recommendation form (SOR) or the RUC summary spreadsheet. **The Research Subcommittee agreed to delete the *primary geographic practice setting* and *primary type of practice* questions from all standard RUC Survey templates.**

    It was noted that societies could propose to Research to add these questions back on a case-by-case basis if they feel these questions are warranted for a specific survey.

  - **Intensity/Complexity Response Options**
    During the April 2024 RUC New Business discussion, a RUC member inquired about the intensity/complexity survey questions and the use of "identical" as the midpoint of the five-point comparison scale included in the standard RUC survey templates or if the midpoint should instead state "similar" intensity/complexity compared to the key reference services. The inquiry was based on a concern that survey respondents may be reluctant to select the term "identical" as this implies an exactness. The RUC referred this item for consideration by the Research Subcommittee at the September 2024 meeting. The Subcommittee discussed this issue in September 2024 though did not come to a decision so tabled the discussion for the future.

During the April 2025 meeting, the Subcommittee noted that the RUC intensity survey question measures intensity relative to the KRS using two degrees of separation with neutral where neutral is "identical." Several Subcommittee members expressed support for switching away from "identical", which many concurred was too exact. Many members expressed support for the term "same". A Subcommittee member noted that they spoke with several survey experts at their health system and the survey experts recommended for the Subcommittee to consider a pilot test and also recommended the use of the term "same". The Subcommittee determined that a pilot test would not be necessary at this time.

The Research Subcommittee agreed to update all standard RUC Survey templates to use the word "same" instead of "identical" for the survey intensity and complexity questions. Subcommittee members also asked AMA RUC staff to track the impact of this decision as new survey data become available and report back after one year of data is available.

- **Maternity Care Services RUC Survey Customization Requests**
  American College of Obstetricians and Gynecologists

The CPT Maternity Care Services (MCS) workgroup submitted a code change application (CCA) for the May 2025 CPT meeting to dramatically restructure how maternity care services will be reported in CPT. In order to prepare for the large (20 CPT codes), multispecialty RUC survey, the American College of Obstetricians and Gynecologists (ACOG) submitted a request to consider changes to the RUC survey template and new vignettes for several codes that are not anticipated to be modified by the Panel.

ACOG noted that the surveying specialties will include the new language on the RUC survey template and require the surveyee to attest to reading the language prior to starting the RUC survey. In addition to the pre survey attestation, the specialties would like permission to modify the standard survey templates to include the related guideline language throughout the survey tool. AMA staff confirmed that these changes do not require Research Subcommittee approval.

Separately, ACOG requested approval to use the 2022 Hospital Inpatient/Observation Services survey template for the four new XXX, per calendar date, labor management CPT Codes. Several Subcommittee members noted that they were not necessarily opposed to the concept, but would be more comfortable to review this request once the full CPT language is approved and available for additional context. Subcommittee members also noted that it would be helpful to be able to compare the updated CPT language to the hospital/observation visit codes as well. The Subcommittee requested for ACOG to submit an updated request for the Subcommittee's next conference call which will be held in mid-May after the final modified CPT language becomes available. ACOG staff and AMA RUC staff will start collaborating on the proposed template in advance for the May Research call.

ACOG requested Research approval of the following maternity care services CPT code vignettes. These codes do not have any proposed long descriptor revisions being considered by the CPT Editorial Panel. They instead are only proposed to be relocated in the CPT Book. **The Research Subcommittee reviewed and approved the following vignettes without modification.**

59320 Cerclage of cervix, during pregnancy; vaginal
Research-approved vignette: A 28-year-old gravida 2, para 1 at 20 weeks and 2 days has shortened cervix. Vaginal cerclage is performed.

59325 Cerclage of cervix, during pregnancy; abdominal
Research-approved vignette: A 35-year-old gravida 4, para 0 at 12 weeks and 6 days has cervical insufficiency. Abdominal cerclage is performed.

59871 Removal of cerclage suture under anesthesia (other than local)
Research-approved vignette: A 28-year-old gravida 2, para 1 at 36 weeks presents for removal of cerclage suture.

59414 Delivery of placenta (separate procedure)
Research-approved vignette: A 31-year old, gravida 3, para 2 requires delivery of placenta (separate procedure).

59160 Curettage, postpartum
Research-approved vignette: A 23-year-old gravida 2, para 2 has postpartum bleeding and retained products of conception. Postpartum curettage is performed.

The RUC approved the Research Subcommittee Report.

X. Practice Expense Subcommittee (Tab 13)

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

The PE Subcommittee considered Tab 7 *Transoral Oropharyngeal Procedures* and noted that the components of EQ137 *instrument pack, basic ($500-$1499)* and EQ138 *instrument pack, medium ($1500 and up)* are not defined. The medium instrument pack EQ138 is included as a direct input for current CPT code 42808 and the society recommended including it for the revised code 42808 *Excision or destruction of lesion of pharynx, without magnification, any method.* The PE Subcommittee agreed with the recommendation but expressed the need to understand the background related to the formation of these packs. **The Subcommittee agreed that AMA staff will research the issue of EQ137 and EQ138 instrument packs to share the history regarding how these packs were developed.**

The RUC approved the Practice Expense Subcommittee Report.

XI. Relativity Assessment Workgroup (Tab 14)

Doctor Amr Abouleish, Chair, provided the report on the Relativity Assessment Workgroup (RAW) to the RUC.

- ***Review of Action Plans***

Doctor Abouleish indicated that the Workgroup reviewed action plans from five screens, comprising 25 families of approximately 80 codes and provided recommendations.

The Workgroup also continued review of codes the RUC flagged as "Do not use to validate physician work" in the RUC database. **The Workgroup recommended to survey the transcatheter aortic valve replacement (TAVR) (33361-33366) and injection anesthetic agent (64400 and 64405)**

codes and to remove the flag for liver elastography code 91200. CPT code 91200 has been surveyed three times, 2014, 2015 and 2020. In 2021, the RUC recommended flagging this service because the survey respondents may have overestimate the intra-service time due in part to the language in the vignette. **The Workgroup determined there is no evidence that code 91200 is misvalued and the flag should be removed.**

- ***2025 Reiteration of Screens – based on 2023 Medicare Utilization***

Outpatient Setting but Includes Hospital Visits

Five codes were identified as a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. Codes 23472, 27130, 27447, 44970 and 63047 were identified. Codes identified via the site of service anomaly screen go straight to the level of interest form for survey at the next meeting. The Workgroup also worked with the specialty societies to identify the families associated with these five services. **The Workgroup recommends codes 23470, 23472, 27130, 27446, 27447, 44950, 44955, 44960, 44970, 63045, 63046, 63047 and 63048 be placed on the LOI and surveyed for September 2025.**

Additionally, the Workgroup will review action plans for approximately 60 codes based on 10 different screens that were reiterated based on current 2023 Medicare data.

- ***Discussion of Potential New Screens***

The Workgroup chair opened up the discussion for examination of two possible new screens:

1. One possible new screen may be codes that have not been reviewed in the past 20 years with Medicare Utilization over 1 million. **AMA staff will run data, and the Workgroup will review a list of these codes at the next meeting.**

2. Another possible screen is revisiting the IWPUT screen. The Workgroup last reviewed the High IWPUT screen in 2008. The High IWPUT screen was based on services with a total Medicare utilization of 1,000 or more with an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in the identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate. **In September 2025, the Workgroup will review codes with an IWPUT greater than 0.14 and determine the next steps.**

The RUC approved the Relativity Assessment Workgroup Report.

XII. Administrative Subcommittee (Tab 15)

Doctor John Proctor provided the report on the Administrative Subcommittee to the RUC. Doctor Proctor noted that the Administrative Subcommittee met as the first meeting of this two-year cycle. The Administrative Subcommittee reviewed the resources available on the RUC Collaboration site and the responsibilities of the Administrative Subcommittee. The overview included reviewing the following:

- RUC Structure and Functions
- Rules and Procedures
- RUC Confidentiality Agreement
- RUC Anti-Lobbying Policy
- Financial Disclosure Policies
    - Statement of Compliance
    - Financial Disclosure for Presenters
    - Financial Disclosure Review Process
- RUC Vendor/Company Attestation
- Rotating Seat Policies and Election Rules
- Annotated List of RUC Actions

The RUC approved the Administrative Subcommittee Report.

XIII. Professional Liability Insurance (PLI) Workgroup (Tab 16)

Doctor Bradley Marple, Chair, provided the report of the Professional Liability Insurance Workgroup.

- **Overview of RBRVS Professional Liability Insurance Methodology**
  Doctor Marple and AMA staff, Mike Morrow, provided an overview of the responsibilities of the PLI Workgroup and CMS' PLI methodology. Doctor Marple noted that the PLI Workgroup is primarily charged with review and recommendation of refinement to Medicare's PLI relative value methodology. He also noted that CMS only reassesses the specialty liability insurance risk premiums that are the main input in the PLI formula once every 3 years, with the next one occurring in the upcoming proposed rule this summer. Therefore, the Workgroup will also have a meeting during the NPRM comment period. At that meeting, the Workgroup would review any proposed policy from the NPRM and provide general guidance on how to respond.

  AMA Staff separately demonstrated how the PLI RVU is calculated for an example CPT code and gave an overview of CMS' PLI methodology in general. He also provided an overview of CMS' policy to have single-specialty PLI risk premium overrides for very low volume services. CMS has a list of approximately 2,000 low volume CPT codes that are subject to this policy currently. The Workgroup will review potential additions to this list at its summer meeting.

The RUC approved the Professional Liability Insurance Workgroup.

XIV. Physician Practice Information Survey (Tab 17)

Carol Kane, PhD, Director of Economic and Health Policy Research and Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA, provided the following information regarding the Physician Practice Information (PPI) Survey:

- Centers for Medicare & Medicaid Services (CMS) Practice Expense Relative Value Unit (RVU) Methodology
  - Complex methodology, relying on the following data sources:
    - Direct practice cost estimates at individual code level
    - Bureau of Labor Statistics for clinical staff compensation
    - Pricing studies for medical supplies and equipment
    - Medicare claims data
    - Work relative value units
    - The American Medical Association's (AMA's) practice cost survey data and supplemental survey data

- Medicare Economic Index (MEI)
  - The MEI is a measure of practice cost inflation that was developed in 1975 to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates.
  - The MEI distribution of physician work, practice expense and professional liability insurance (PLI) is used to determine the weights of these relative value pools.

	1975-1992	1993	1996	2000	Currently Used – 2006 Data	Updated CMS MEI Weights (Postponed)
Physician Work	60.0%	54.2%	54.5%	52.5%	50.9%	47.5%
Practice Expense (PE)	40.0%	41.0%	42.4%	43.7%	44.8%	51.1%
Professional Liability Insurance (PLI)	(incl with PE)	4.8%	3.2%	3.9%	4.3%	1.3%

* AMA Comment: New CMS MEI is flawed because it excludes hospital-based physicians.

- AMA Socioeconomic Monitoring System (SMS)
  - The SMS, an annual phone survey of 4,000 physicians, was conducted from the early 1980s through 1999.
  - SMS surveyed physician practice arrangements, managed care involvement, income and expenses, and hours and weeks of work.
  - SMS utilized for MEI – supported the 60% work, 40% PE used through 1992.
  - Core 1989 SMS Survey used to establish MEI for the 1993 Resource Based Relative Value Scale (RBRVS).
  - SMS Data used to update MEI in 1996 and 2000
  - Resource-based PE RVUs in 1999 – SMS 1995-1999 data were utilized.

- Physician Practice Information (PPI) Survey 2007/2008
    - In 2010, CMS began a four-year transition to employ new practice expense data from the Physician Practice Information (PPI) Survey.
    - Survey was administered by **dmr**kynetec via phone, fax, mail, and online.
    - Jointly funded by CMS, AMA and national specialty societies.
    - 2006 practice expense per hour was reported based on PPI data from 2,795 physicians.

- Other PPI, Crosswalk, and Specialty Society Supplemental Surveys
    - **dmr**kynetec also administered surveys for non-MD/DO health care professionals.
    - CMS cross-walked data for 34 specialties to other like specialties.
    - CMS does not utilize claims data from Nurse Practitioners or Physician Assistants in the current methodology because PE/Hour data were not available.
    - Supplemental survey data implemented for Medical Oncology, Independent Diagnostic Testing Facilities (IDTFs) and Independent Labs.

- AMA House of Delegates (HOD) Resolution
    - In June 2019, the AMA HOD referred for decision a request for the reengagement in practice cost data collection
    - The AMA Board of Trustees directed AMA staff to conduct physician interviews and a pilot study to determine the feasibility of a new data collection effort.

- Physician Practice Interviews 2020 and 2022
    - In early 2020, AMA staff interviewed financial experts representing various physician practice types to inform a contract for a larger interview process.
    - The AMA retained Medscape to interview and pilot survey 50 physician practices in summer 2020. One key finding was that it was necessary to query the financial experts in the practice directly. Also advised to pause until after COVID impacts to practices.
    - In 2022, the AMA interviewed an additional 20 larger physician practices and health systems, met with CMS and obtained budget approval to proceed with a 2023-2024 PPI Survey effort.

- PPI Survey Development
    - The AMA retained Mathematica and provided significant resources to design and administer a new PPI Survey in 2023-2024.
    - The PPI survey was designed based on previous effort, CMS definitions, learnings from the interviews and pilot testing. Specialties were also provided with the opportunity to review and provide comment in late 2022.
    - Mathematica pre-tested and piloted the survey prior to launch in summer 2023.

- Example of a Table From the PPI

TABLE A. Physicians: ANNUAL Work RVUs, and ANNUAL Compensation, by specialty in [2022/2023]						
Part 1	**Average # of physicians at the practice during [2022/2023]**				**Total ANNUAL COMPENSATION for ALL physicians**	
Physician Specialty	**1a. part-time *(less than [Y] hours per week)***	**1b. full-time *(at least [Y] hours per week)***	**2. Percent of time physicians billed in non-facility settings**	**5. Total ANNUAL work RVUs provided by ALL physicians**	**6a. Monetary compensation**	**6b. Benefits**
[SPECIALTY]						
[SPECIALTY]						
TOTAL	*Total*	*Total*		*Total*	*Total*	*Total*

- PPI Survey Support Letter – 170+ organizations
  - More than 170 organizations signed a letter of support to share with all potential survey respondents. All state medical associations; more than 100 national medical specialty societies and other health care professional associations; American Group Medical Association; Medical Group Management Association; and the Association of American Medical Colleges all signed the letter.
  - Nearly all these organizations sent out additional communications to support the effort in 2023-2024.

- PPI Survey Incentives
  - Small practices (i.e., fewer than 10 physicians) were offered $100 to complete survey.
  - All survey respondents offered a complimentary one-year online subscription to the AMA's RBRVS DataManager.
  - Tested offering $500 to medium sized practices and $1,000 to large practices. Incentives to larger practices were not effective, so was not extended.

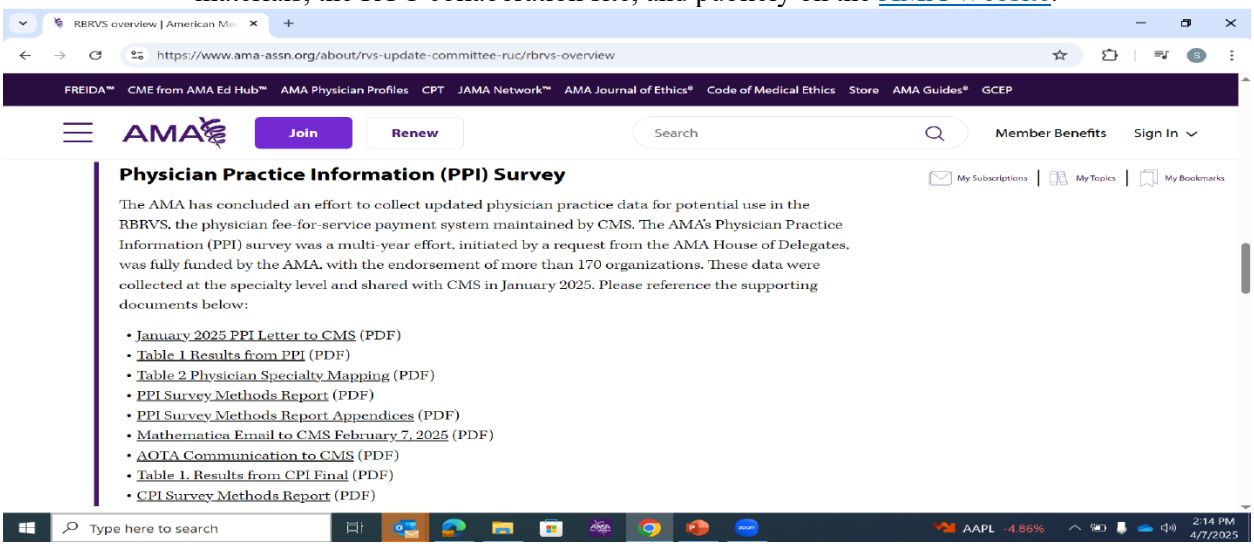
- PPI Survey Sample and Practice Information
  - Practices were defined by Taxpayer Identification Numbers (TINs). Sampling using TINs aligns with available information in the Medicare Data on Provider Practice & Specialty (MD-PPAS). MD-PPAS includes physicians who have billed Medicare.
  - Practice information from IQVIA's OneKey data was linked to MD-PPAS to find information on names and contact information of financial experts.
  - IQVIA OneKey data used directly to select pediatric medicine sample.
  - Sampling and weighting variables will be discussed in later slides.

- PPI Survey Administration
  - Institutional Review Board approval received.
  - E-mails to physician practice sample began in late July 2023.
  - E-mails to non-MD/DO practice, IDTFs and independent labs sample began in early 2024.
  - Availability and reliability of e-mail addresses within the IQVIA's OneKey data was an issue. AMA and Mathematica conducted numerous lookups to improve information. Nearly 20% of the sample selected did not have accurate financial expert names or contact information. An additional 40+% had names but no email information.
  - Mathematica also mailed the surveys to each practice.

- Direct Patient Care Hour Surveys
    - Mathematica emailed physicians from the sampled practices to collect patient care hours and to inform those physicians that their practice was invited to participate in the PPI Survey effort.
    - The AMA and Medscape also directly contacted physicians to collect direct patient care hours and encourage physician engagement to ensure practice surveys were completed.
    - Reponses to the hours survey were received from 5,690 physicians.

- PPI Survey Concluded September 2024
    - The PPI Survey concluded with 380 practices providing usable data for 831 departments. These departments included 18,086 physicians. Some practices were also able to allocate costs to nurse practitioners and physician assistants. The response rate was 6.8%.
    - The non-MD/DO survey concluded with 317 practices providing usable data and included 2,548 other health care professionals. The response rate was 9.1%.
    - Practice expense and direct patient care hour data for physicians and other health care professionals were submitted to CMS in advance of the February 10, 2025, due date. The IDTF community has not yet submitted survey data to CMS as they are working to determine a direct patient care hours alternative.

- PPI Survey Resources on AMA Website
    - The PPI Survey Resources are in the Relative Update Committee (RUC) agenda materials, the RUC collaboration site, and publicly on the AMA Website.



- Differences between 2007/2008 and 2023/2024 PPI Survey Efforts
    - Previous PPI focused on the individual physician; New PPI focused on the practice (TIN).
    - Previous PPI sample from the AMA Physician Professional Data; New PPI sample from MD-PPAS (OneKey for pediatric practices).
    - Previous PPI was administered via phone, fax, mail, and online; New PPI administered solely online.
    - Previous PPI point of contact was the physician; New PPI point of contact was the financial expert.

- PPI Sampling
  - Practices were defined as TINs and selected from the MD-PPAS data (OneKey for pediatric practices).
  - TINs were sampled based on practice attributes thought to be correlated with practice expense.
    - Practice size
    - % of allowed charges in a facility setting
    - Whether single (39) or multi-specialty (6)
    - Practice ownership

- Combining Specialty-level Data
  - Practices were asked to provide expense data separately for each Medicare specialty (65) in their practice.
  - Because of small sample size and because some practices combined specialties when reporting, we grouped expense data into 18 categories. Table 2 on the earlier linked website provides the full mapping.
  - Combinations were based on similarities across specialties in 2006 expense data, similarities in site-of-service billing, and function.

- Calculation of practice expense per hour (PE/HR)
  - Physician Hours Survey
    - Grouped the hours data into 18 specialty categories.
    - Defined a physician as full time (hours >= 35) or part time.
    - Computed mean hours and mean weeks separately for full and part time physicians in each specialty category.

	Hours per week	Weeks per year	Hours per year
Part time	21	43	930
Full time	52	45	2316
All	44	44	1936

- Calculation of PE/HR (continued)
  - Practice Survey
    - Excluded departments that did not report any expense data or had number of physicians inconsistent with other data reported.
    - Calculated annual total hours of patient care for each department. Multiplied the numbers of physicians in each department by mean hours and mean weeks, separately for full and part time physicians.
    - Divided each expense variable by annual total hours of patient care.
    - Trimmed outliers.
    - Imputed missing values based on specialty means and, depending on expense category, subcategories within specialty (% of billing in the facility setting or size).

- Weighting
  - Due to sample size, the weighting methodology was based on only subset of variables (and categories) used in sampling, prioritizing those thought to have the greatest correlation with practice expense.
  - Weights accounted for practice specialty; % of billing in the facility setting within each practice; specialties within each of the 18 groupings; and practice size.

- Annual Hours, Direct, Indirect, and Total PE/HR: Physicians

Broad specialty	Mean annual hours of direct patient care	Mean direct PE/HR	Mean indirect PE/HR	Mean PE/HR
Cardiology	2265	77.55	132.00	209.55
Dermatology	1636	103.82	146.63	250.46
Gastroenterology	2025	54.31	117.02	171.34
Hematology/Oncology	1763	109.62	132.38	242.00
Hospital Based Medicine	1768	6.61	56.52	63.13
Hospital Based Surgery	2448	32.54	62.39	94.93
Obstetrics/Gynecology	2063	61.57	101.05	162.62
Office Based Medicine	1849	34.60	75.32	109.92
Office Based Proceduralist	2170	63.03	110.95	173.98
Ophthalmology	1812	96.83	200.36	297.19
Orthopaedic Surgery	2397	41.65	113.50	155.15
Otolaryngology	2296	47.91	100.44	148.3
Pathology	2036	19.13	46.79	65.92
Primary Care	1851	48.55	97.14	145.70
Psychiatry	1407	9.25	28.84	38.10
Pulmonary Disease	2028	41.00	92.44	133.43
Radiology	1781	58.79	118.12	176.91
Vascular Surgery	2486	87.96	117.35	205.32
All	1936	42.56	91.04	133.61

- Annual Hours, Direct, Indirect, and Total PE/HR: Health Care Professionals

Broad specialty	Mean annual hours of direct patient care	Mean direct PE/HR	Mean indirect PE/HR	Mean PE/HR
Audiology	1498	34.15	123.60	157.75
Chiropractic	1652	40.69	64.44	105.13
Clinical Laboratory	1723	109.45	103.50	212.94
Clinical Psychology/Psychology	1377	14.73	45.39	60.12
Licensed Clinical Social Worker	1385	25.04	23.85	48.89
Nurse Practitioner	1509	38.03	41.94	79.97
Optometry	1548	125.05	118.69	243.74
Oral Surgery	1524	243.89	338.41	582.29
Physical Therapy	1648	29.48	59.21	88.69
Physician Assistant	1583	32.59	49.59	82.18
Podiatry	1592	43.70	89.95	133.65
Registered Dietitian	1036	21.87	41.55	63.42
Speech Language Pathology	982	9.71	26.93	36.64

- Components of Direct and Indirect PE/HR (all physicians)

Clinical	Supplies	Equipment	Total direct
33.02	6.77	2.77	42.56

Administrative	Overhead	Information technology	Other	Total indirect
29.30	24.29	6.55	30.91	91.04

- Medicare Economic Index (MEI)

	1975-1992	1993	1996	2000	Currently Used – 2006 Data	Updated CMS MEI Weights (Postponed)	2024 PPI
Physician Work	60.0%	54.2%	54.5%	52.5%	50.9%	47.5%	60.8%
Practice Expense (PE)	40.0%	41.0%	42.4%	43.7%	44.8%	51.1%	37.0%
Professional Liability Insurance (PLI)	(incl with PE)	4.8%	3.2%	3.9%	4.3%	1.3%	2.3%

*AMA Comment: New CMS MEI is flawed because it excludes hospital-based physicians.

- What do Size and Site-of-Service Have to do With it?
  - As practice size increases...
    - Direct and indirect PE contribute a smaller share of the total.
    - Fixed costs spread across more physicians.
    - Work contributes a larger share.
  - As the share of billing in the facility setting increases…
    - Direct and indirect PE contribute a smaller share of the total.
    - The facility incurs some direct and indirect expenses.
    - Work contributes a larger share.

- Practice Size Variation in Practice Expense & MEI

Practice Size	Total direct	Total indirect	Total PE	Provider work	PLI	MEI Expense
Practice expense per hour						
1 to 10	48.67	93.42	142.09	140.00	6.00	288.09
11 to 100	43.30	98.11	141.41	232.30	4.89	378.61
101+	34.11	76.50	110.61	202.69	8.58	321.61
Missing	76.23	163.43	239.67	234.42	4.75	478.84
All	42.56	91.04	133.61	194.32	6.95	334.87
MEI						
1 to 10	15.8%	31.8%	47.6%	50.1%	2.3%	100%
11 to 100	8.4%	23.7%	32.1%	66.5%	1.4%	100%
101+	9.5%	22.5%	32.1%	65.2%	2.8%	100%
Missing	14.8%	30.6%	45.5%	53.3%	1.2%	100%
All	11.3%	25.7%	37.0%	60.8%	2.3%	100%

- Department Billing Variation in Practice Expense & MEI

% of billing in facility	Total direct	Total indirect	Total PE	Provider work	PLI	MEI Expense
Practice expense per hour						
Less than 25%	59.19	108.06	167.25	176.52	7.90	351.66
25% to LT 50%	61.07	116.89	177.96	220.65	9.46	408.08
50% to LT 75%	56.04	99.71	155.75	211.01	5.65	372.40
75%+	29.94	83.04	112.98	195.85	6.71	315.54
Missing	50.52	85.99	136.51	193.45	6.32	336.29
All	42.56	91.04	133.61	194.32	6.95	334.87
MEI						
Less than 25%	15.3%	29.7%	45.0%	52.7%	2.4%	100%
25% to LT 50%	14.7%	27.8%	42.6%	54.8%	2.6%	100%
50% to LT 75%	13.1%	26.4%	39.5%	59.8%	1.7%	100%
75%+	8.4%	24.8%	33.2%	64.5%	2.3%	100%
Missing	13.7%	23.5%	37.2%	60.5%	2.3%	100%
All	11.3%	25.7%	37.0%	60.8%	2.3%	100%

- Practice Billing Variation in Practice Expense & MEI

% of billing in facility	Total direct	Total indirect	Total PE	Provider work	PLI	MEI Expense
Practice expense per hour						
Less than 25%	62.57	106.55	169.12	159.08	6.46	334.66
25% to LT 50%	68.17	135.00	203.17	221.20	6.01	430.38
50% to LT 75%	40.01	91.66	131.68	218.01	10.05	359.74
75%+	19.01	56.43	75.44	188.28	6.60	270.32
Missing	70.24	139.30	209.54	199.47	4.58	413.60
All	42.56	91.04	133.61	194.32	6.95	334.87
MEI						
Less than 25%	16.8%	31.4%	48.2%	49.5%	2.4%	100%
25% to LT 50%	13.9%	30.1%	44.1%	54.3%	1.7%	100%
50% to LT 75%	10.7%	24.9%	35.6%	61.9%	2.6%	100%
75%+	6.8%	20.8%	27.6%	69.9%	2.5%	100%
Missing	16.8%	30.7%	47.5%	51.1%	1.4%	100%
All	11.3%	25.7%	37.0%	60.8%	2.3%	100%

- Regressions That Control for Specialty Show…
  - On average, in practices with 50 or more physicians compared to practices with 10 or fewer physicians:
    - Overhead per hour is $19 lower
    - Direct shares are 11 percentage points lower
    - Indirect shares are 12 percentage points lower
  - On average, a 1 percentage point increase in facility billing for a department is associated with a:
    - $0.33 decrease in direct PE/HR
    - $0.48 decrease in indirect PE/HR

- Concluding thoughts
    - Participation still hard to obtain but for different reasons.
    - Physicians are no longer the appropriate point of contact. 44% of physicians were owners in 2022 compared to 61% in 2007.
    - Practices (TINs) are a better point of contact but contact information is lacking.
    - Even when contact information is accurate, security measures (SPAM filters) affect response.
    - Some practices track expenses across TINs or within TINs.
    - Some practices don't track expenses at the detailed specialty level currently used by CMS.
    - Attention must be paid to sampling and weighting. While physician characteristics were key in 2007 (e.g., age and gender) practice characteristics (e.g., size and site-of-service) are now more important.

XV. New/Other Business (Tab 18)

- A RUC member requested available Medicare Advantage data from CMS to inform the RUC process. AMA staff described an active search for other commercial data and continued requests for CMS to provide data for RUC purposes. This includes ongoing conversations and comment letters.

- A RUC member stated that the codes flagged for "do not use to validate physician work" should be cautionary rather than definitive. The Chair of the Relativity Assessment Workgroup (RAW) reviewed the current process of re-review for all codes flagged in the RUC database to ensure the "do not use to validate physician work" flag is appropriate. The Vice Chair of RAW also commented that using the codes to validate physician work for other codes could exacerbate the number of flagged codes. Specifically, the following was discussed by the RAW at the April 2025 meeting:
    - "***RUC Flag Review***
      At the January 2025 meeting the Relativity Assessment Workgroup determined that it should reexamine the other specific flagged codes that are currently flagged in the RUC database, in detail by reviewing an action plan from the specialty societies. The Workgroup will spread this review over the next three meetings, first looking at the top 1/3 of codes with the highest Medicare utilization.

      The Workgroup reviewed action plans to determine if the top DNU specific flagged codes should be resurveyed, revised at CPT, maintained with the flag or the flag removed. The goal will be to find a way to resolve the issue that led to the flag, if possible. The Workgroup noted if a code is on the new technology/new services list already scheduled for review, that those codes be maintained on that list and address the new technology/new service and DNU flag at the same time."

- A RUC member requested that the RAW look at the annual CMS inpatient only list for services performed in the outpatient setting. Annual review of the data instead of at 3 years may more promptly confirm site of service accuracy. The Chair of the RAW stated that the 3 years is to make sure it creates a site of service abnormality, and once a service is over 50% outpatient instead of inpatient then it would be flagged for review. That said, there is a point if the data is overwhelmingly outpatient after 1 year (eg, over 80%), however, below that it could be an abnormality so 3 years may be a better standard in the majority of circumstances. **This item was referred to the RAW for further discussion.**

- A RUC member stated that a recent AMA House of Delegates (HOD) report discussed information that may be gleaned from electronic health record (EHR) data for RUC purposes. AMA staff have completed significant research on this topic over several years. The AMA has contacted a few of the major EHR companies to determine availability of time-related data. Nate Apathy, PhD, a researcher from the University of Maryland developed a database of certain elements from EHR data and AMA staff had an informative discussion with him. It was suggested that Nate Apathy, PhD, be invited to present to the Research Subcommittee on what is and is not available in current EHR data relevant to the RUC process.

- A RUC member requested clarification on the selection of family codes to be surveyed with new and revised CPT codes and CMS/RAW related items and further suggested that criteria be developed. AMA staff clarified that in previous five-year reviews, the RUC would often just review a single identified code in isolation. Around 2013, CMS started to express concern that families were not addressed and began accepting values as interim with a request to re-survey along with the applicable code family. It was at that time that the RUC started to take responsibility for reviewing the applicable code family to prevent additional burdensome work with re-surveys. In the current RUC process, the specialties are to identify the code family for the RAW action plan and that should be recorded in the RAW report to define the family at that time. For the new and revised CPT codes, there are discussions by AMA staff, CMS, and the specialties on the defined family. Further, the RUC Observer reviews the LOI and Category I code families, and AMA staff connect with the applicable specialty societies to determine the appropriate code family. Further, CMS reviews both the CPT and CMS/RAW LOI's and sometimes CMS submit comments for consideration and sometimes they agree with the families as listed. Additionally, it is important to consider how the codes are currently reported which impacts relativity and is reflected in the budget neutrality calculation that is developed and sent to CMS. At this April 2025 meeting specifically, there are several tabs that had issues with the families leading tore-survey as determined by the RUC. The goal is to accurately define the families correctly so that multiple code families and such are not nominated for re-review in a Proposed or Final Rule. Several RUC members thanked AMA staff for the detailed response and cautioned against creating guidelines as the current adjudication process is sufficient. It was also suggested that RAW members should review the families for their assigned action plans.

The RUC adjourned at 10:13 AM CT on Saturday, April 26, 2025.

AMA/Specialty Society RVS Update Committee Meeting

April 25, 2025

Ezequiel Silva III, MD, Chair
Peter Hollmann, MD, Vice Chair

RUC Chair Report

Ezequiel Silva III, MD, Chair

Conference Etiquette

- The RUC process is successful due to the expertise, diligence and professionalism of all participants. We depend upon the respect and professional courtesy accorded to every participant.
- All participants shall treat each other with respect and courtesy during this meeting and in all our interactions.

Meeting Confidentiality

All attendees shall respect our confidentiality provisions indicated in the agreement to which you attested via the registration process. Please recall that:

- Confidentiality requirements extend to both materials and discussions at this meeting.
- All recording devices are prohibited (including AI for notetaking). *Please note the AMA is recording this meeting.*
- Full confidentiality agreement found on Collaboration site. *(Structure and Functions)*

Lobbying Policy

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

Professional.

Ethical.

Welcoming.

Safe.

The AMA has a robust Code of Conduct for AMA-sponsored meetings to ensure a professional and ethical environment for all attendees.

Everyone should feel welcome, safe and able to participate without fear of unwelcome conduct in-person or through electronic communication (social media, texting, apps, etc.).

The Code of Conduct also covers behavior during social events and gatherings held during the meeting, as well as interactions between members and AMA staff.

The AMA has zero tolerance for any harassment of any attendee at an AMA hosted meeting or event.

Professional.

Ethical.

Welcoming.

Safe.

If you have any questions about the Code of Conduct, are aware of behavior that may have violated this policy, or would like to report an incident, you can submit information in the following ways:

- The Conduct Liaison assigned to the meeting: Kyle Palazzolo, Assistant General Counsel at (312)-464-4698 or kyle.palazzolo@ama-assn.org
- The AMA's Office of General Counsel at codeofconduct@ama-assn.org
- The presiding officer for the AMA meeting you are attending
- The third-party hotline at 1-800-398-1496, or online @ Lighthouse, which can be submitted anonymously.

Training materials regarding the Code of Conduct can be accessed below: Harassment in Professional Settings: Building Awareness to Support Prevention – Addressing Harassment at Meetings and Events

Financial Disclosures

- All RUC Members have completed a statement of compliance with the RUC Financial Disclosure Policy.
- We have no stated disclosures/conflicts for the meeting.

CPT Editorial Panel

- Timothy Swan, MD – CPT Panel Member

CMS Medical Officers

- Perry Alexion, MD
- Arkaprava Deb, MD
- Stefanie Fischell, MD
- Edith Hambrick, MD

Medicare Payment Advisory Commission (MedPAC)

- Rachel Burton, MPP – Principal Policy Analyst
- Geoff Gerhardt, MPP – Principal Policy Analyst
- Brian O’Donnell, MPP – Principal Policy Analyst

New RUC Members

- Luke Barré, MD - American College of Rheumatology (ACRh)
- Leisha Eiten, AuD, CCC-A – Health Care Professionals Advisory Committee (HCPAC)
- Anne Miller, MD – American Society of Surgery for the Hand (ASSH)
- Sanjay A. Samy, MD - Society of Thoracic Surgeons (STS)

New RUC Alternates

- Timothy Laing, MD – American College of Rheumatology (ACRh)
- James Levett, MD – Society of Thoracic Surgeons (STS)
- Noah Raizman, MD – American Society of Surgery for the Hand (ASSH)
- Korinne Van Keuren, DNP, MS, RN – Health Care Professionals Advisory Committee (HCPAC)

Departing RUC Member

- James Waldorf, MD (ASPS)
- RUC Member 2008-2025

Thank you and Farewell!

Reviewer Guidelines

- To enable more efficient RUC reviews, AMA staff reviewed specialty SORs for adherence to our general guidelines and expectations, such as:
  - Specialty representation
  - Survey methodology
  - Vignette
  - Sample Size
  - Budget Neutrality / Compelling evidence
  - PLI
  - Moderate Sedation

Procedural Issues: RUC Members

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

Procedural Issues: Voting

- Work RVUs = 2/3 vote
- Motions = Majority vote
- RUC members will vote using the voting link provided via email (Qualtrics)
- **There is only one link for all votes!**
- You may submit your vote via computer or smart phone.
- If you are unable to vote during the meeting, please notify AMA staff.

Procedural Issues: Voting

- RUC votes are published annually on the AMA RBRVS web site each July for the previous CPT cycle.
- We vote on every work RVU, including facilitation reports
- If members are going to abstain from voting, please **notify AMA staff** so we may account for all 29 votes
- *Run test vote now*

Procedural Issues

- At any time if specialty society presenter requires time to deliberate, please notify the RUC Chair.
- If RUC Advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC Chair or Sherry.Smith@ama-assn.org

Procedural Issues: RUC Ballots

- All RUC members were sent an email with a link to submit a ballot if the initial vote does not pass
- If a tab fails **all** RUC Members must complete a ballot on the code that failed and any remaining codes in the family, to aid the facilitation committee
- You must enter the work RVU, physician times and reference codes to support your recommendation.

Procedural Issues: New Business

- Throughout this meeting, if you have potential items for new business, please let AMA staff and/or me know so we may guide you to existing resources, if applicable.

Research Subcommittee

- The Research Subcommittee meeting reports are included in the Research Subcommittee folder.
- For ease, you will see excerpts from the Research Subcommittee report that pertain to each specific tab, if applicable.

Director’s Report

Sherry L. Smith, MS, CPA

Physician Payment Policy & Systems

Subcommittees and Workgroups

- The Subcommittee and Workgroup composition are restructured every two years coinciding with the Chair's term.
- The Subcommittee and Workgroups have been restructured for a new term (March 1, 2025 – February 28, 2027).

RUC Database – 2025 v 2.0

- Available at https://rucapp.ama-assn.org
- Orientation is available on YouTube https://youtu.be/3phyBHWxlms
- Accessible both online and **offline** from any device, including smartphones and tablets.
- **Download** offline version, you will be prompted whenever there is an update available.
- Be sure to **clear cache** and **log off** before downloading a new version.
- Access has been granted to all RUC participants using the ***same*** Microsoft account that you already use to access the RUC Collaboration Website.
- Current version has 2023 Medicare claims data and 2025 CF.
- Includes more specific Do Not Use to Validate Physician Work flags.

RUC Process Webinars

- We have 12 presentations/webinars to assist all participants in the RUC process!
- You may access the RUC Process webinars via the RUC Collaboration home page or click “General Resources” from the left navigation bar and then “New to the RUC” and “RUC Process Webinars & Presentations”
- Or via direct YouTube link: https://www.youtube.com/playlist?list=PLpUAhDflHfcoS89T0wxivYpHmsYl8fxZp

Upcoming RUC Meetings

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Aug 26, 2025	Sep 25-27, 2025	Chicago, IL	CPT 2027
Dec 9, 2025	Jan 14-17, 2026	Los Angeles, CA	CPT 2027
Mar 31, 2026	Apr 22-25, 2026	Chicago, IL	CPT 2028

CME for RUC Meeting Participation

- Physicians can earn up to **22.00** AMA PRA Category 1 Credits™ and non-physicians can earn a Certificate of Participation.
- To claim CME credit(s) or Certificate of Participation complete the evaluation provided by AMA Staff at the conclusion of the RUC meeting on or before **May 2, 2025**.
- Once you've successfully completed the evaluation, a certificate will be automatically available on **May 16, 2025**, in the "Transcript" section of your AMA Ed Hub account.

AMA Staff Assistance

- If you require assistance regarding RUC member voting or RUC Collaboration site, contact David.Harms@ama-assn.org

- For general meeting assistance, contact Eileen.Donohue@ama-assn.org

Vote to Approve January 2025 RUC Meeting Minutes

Physicians' powerful ally in patient care

CPT Editorial Panel Update to April 2025 RUC Meeting

Tim Swan, MD
CPT Editorial Panel Member

Panel Meeting Activity

RUC Referrals Reviewed at the February 2025 Panel Meeting:

- Computer Assisted Surgical Navigation Revise 20985 (Tab 7)
- Prostate Biopsy Services (Tab 16)
- Autonomic Function Testing (Tab 30)
- Laser Treatment for Psoriasis-Revise 96920 (Tab 35)

May 2025 Panel Meeting

77 Code Change Applications (CCAs) Submitted

Notable agenda items:

- 1 Vaccine CCA for expedited review
- 7 Digital medicine related CCAs
- 26 Category III code applications
- 2 RUC referrals to CPT
- 4 Codes for CPT Code Set Maintenance
- SI Joint Fusion

May 2025 Panel Meeting

RUC Referrals to CPT to be Reviewed at the Upcoming May 2025 Panel Meeting:

- Femoral Osteoplasty-Delete 27468 (Tab 16):
- Rotational Vestibular Assessment (Tab 49):

CPT Ad Hoc Workgroups

Maternity Care Services Workgroup

- Co-Chairs: Padma Gulur, MD; Timothy L. Swan, MD
  - A code change application was submitted by the workgroup with feedback from stakeholders for the May 2025 CPT Editorial Panel Meeting.
  - Currently the proposal includes 12 newly proposed codes and 4 revised codes with 16 code deletions.
  - Four new labor management codes, two vaginal delivery codes, two cesarean delivery codes, one new code for hysterectomy during a cesarean, one new procedure code for uterine tamponade and two new procedure codes for episiotomy repair for 3rd or 4th degree lacerations.
  - The Workgroup is continuing to refine the proposal as appropriate based on Advisor and Interested Party feedback.
  - This request will be reviewed at the May Panel meeting next week.

CPT Ad Hoc Workgroups

Value Based Care Services Workgroup

- Co-Chairs: Leo Bronston, DC MAppSc; Samuel Church, MD; Steven Hao, MD
  - The Value-Based Care Services Workgroup was established following the priorities identified during a July 2024 special strategic session of the CPT Editorial Panel. The Workgroup's last meeting was on April 7th. The Workgroup members discussed potential updates to current coding for care management services. The items for discussion included:
    - Revisions to the guidelines to expand the members of the care team whose activities can be included in the overall time of the service when the care team member is under the direction of a physician or other QHP.
    - Clarification regarding the type of supervision of the care team that is required.
    - Removal of time requirements.
  - The workgroup had a good discussion, and it was decided that AMA staff would begin drafting a code change application to expand the language around care-team members to address the staff issue. The group determined that the supervision issue will be addressed through education. The group decided against revising the time requirements for care management services.

September 2025 Panel Meeting

- The next Panel meeting is September 18-20, 2025 (Thursday-Saturday) Chicago, Illinois
- **The next application submission deadline is June 11, 2025.**

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national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

CMD Updates

Janet Lawrence, MD, MS, FACP
National Government Services
Contractor Medical Director (CMD)
April 2025

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMD Updates

- Nothing of note to report at this time
- Please feel free to reach out to me (janet.lawrence@elevancehealth.com) or your MAC Contractor Medical Directors with questions or concerns until the next RUC Meeting
- Looking forward to being back with you in the Fall

AMA
AMERICAN MEDICAL ASSOCIATION

Washington Report
April 2025

Jennifer Hananoki
Assistant Director, Federal Affairs

Medicare Payment

2025 Medicare Physician and QHP Payment

2025 Medicare conversion factor decreased by **2.83%**

2025 inputs costs as measured by the Medicare Economic Index increased by **3.5%**

- Congress did **not** address the Medicare pay cut in the short-term Continuing Resolution that funds the federal government through the end of the fiscal year
- Negotiations around the CR primarily focused on avoiding a government shutdown, leaving several key policies such as physicians QHP payment relief on the sidelines

AMA Statement: Congress abandons Medicare patients and their physicians

“Physicians across the country are outraged that Congress’s proposed spending package locks in a devastating fifth consecutive year of Medicare cuts, threatening access to care for 66 million Medicare patients. Despite repeated warnings, lawmakers are once again ignoring the dire consequences of these cuts and their impact both on patients and the private practices struggling to keep their doors open.

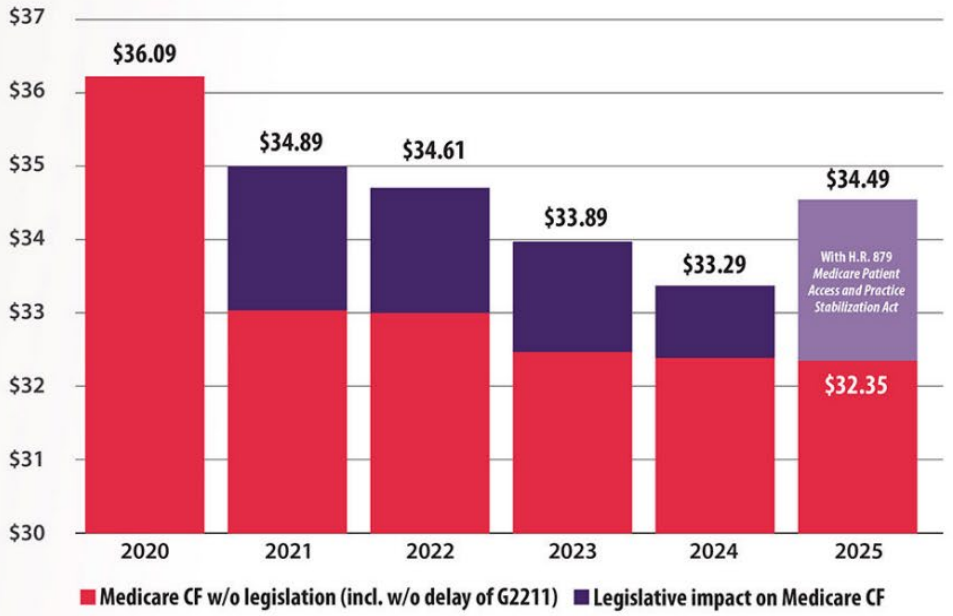
“Today’s decision to allow the 2.8 percent cut to go forward is particularly devastating for rural and underserved communities. These physicians and their patients have borne the brunt of the rising practice costs – 3.5 percent this year according to Medicare’s own estimate. When adjusted for inflation, Medicare payment to physician practices has dropped 33 percent (PDF) since 2001. Let me be clear: These unsustainable cuts will force more practices to close and leave patients with fewer options for care.

“Congress has failed physicians, and Medicare patients will pay the price. The window to reverse this reckless decision is rapidly closing. Lawmakers must explain either why protecting access to quality health care is not a priority or how they plan to fix it.”

Five years of decline in the Medicare conversion factor (2020–2025)

Medicare conversion factor with and without temporary patches

Since 2020, the conversion factor has **fallen by over 10%**.



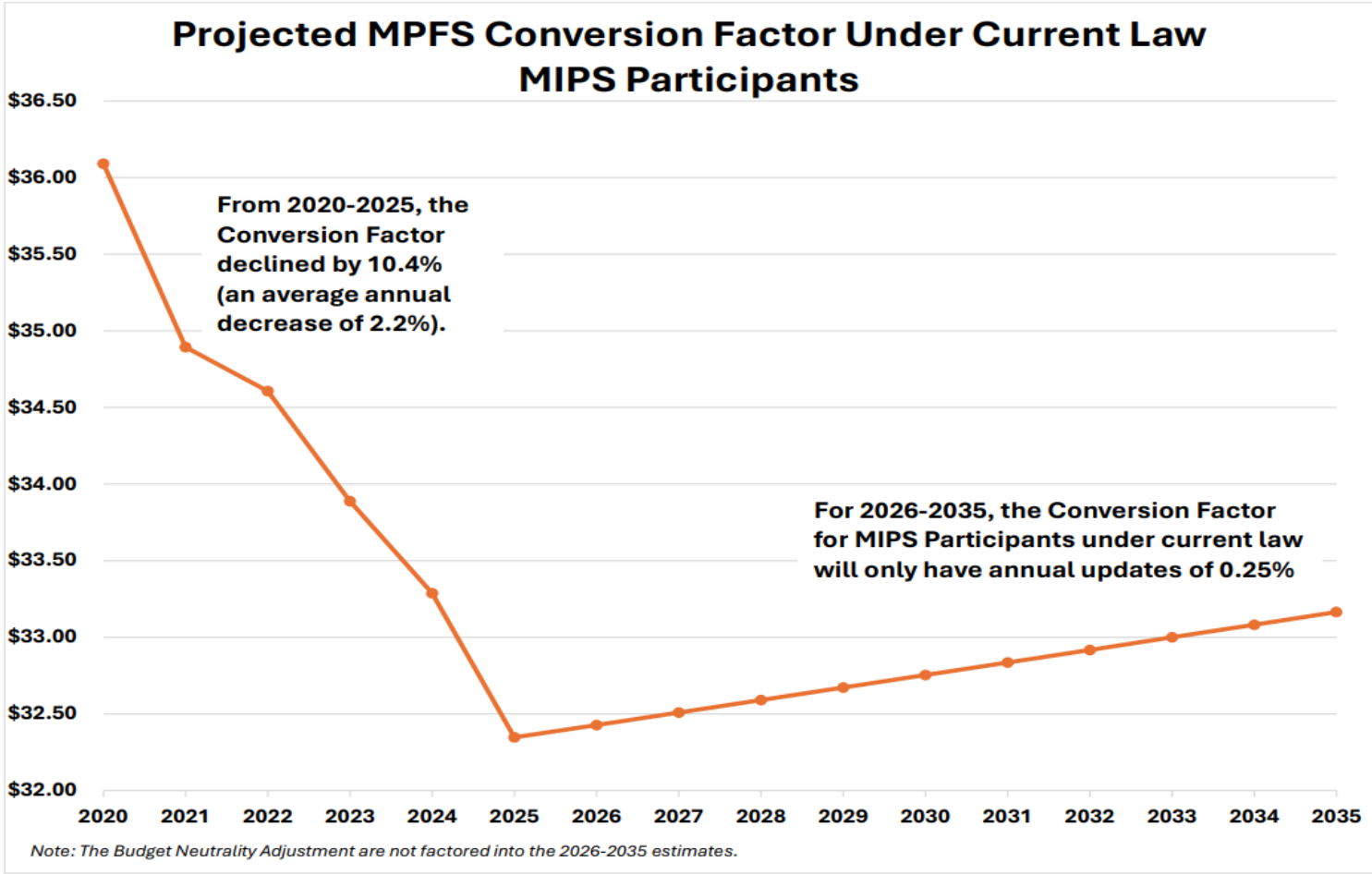
AMA
AMERICAN MEDICAL ASSOCIATION

MedPAC Supports MEI-Based Payment Updates

- For the third consecutive year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress ***permanently*** update Medicare physician and QHP payment based on a portion of MEI
  - 2024: 50% of MEI
  - 2025: 50% of MEI
  - 2026: MEI minus 1 percentage point
- AMA President Scott statement: “MedPAC gives Congress a roadmap to Medicare reform”

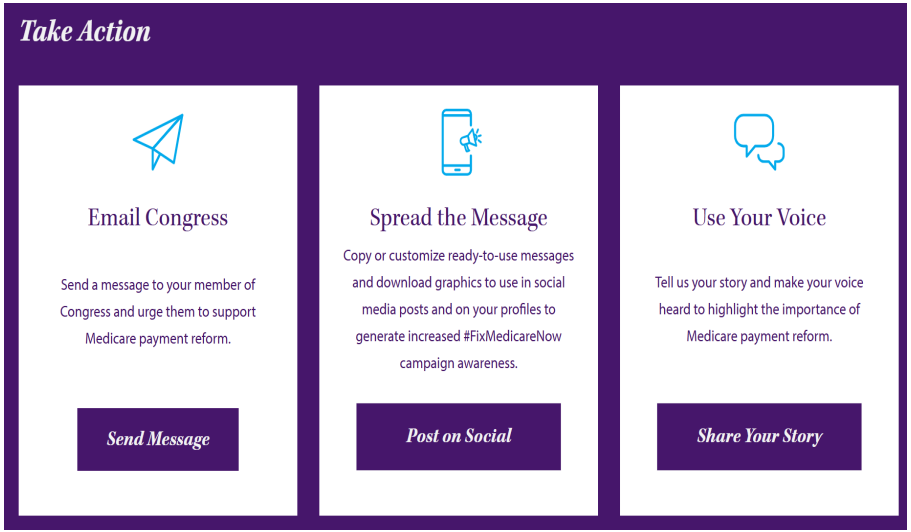
MedPAC and Long-Term Medicare Payment Reform

- MedPAC voted on long-term Medicare physician payment reform recommendations at April 2025 meeting including replacing current law updates with automatic, annual updates based on a portion of MEI (such as MEI minus 1 percentage point) to include in their June 2025 Report to Congress
- AMA President Scott statement: “AMA: Congress should listen to MedPAC on Medicare reform”
- MedPAC will also recommend Congress direct CMS to improve the accuracy of Medicare’s relative payment rates for clinician services by collecting and using timely data that reflects the costs of delivering care
    - Updating aggregate allocation of RVUs
    - Improving the relative accuracy of global surgical codes
    - Improving the accuracy of payment rates for indirect PE



Tell Congress to Support H.R. 879

- H.R. 879, the Medicare Patient Access and Practice Stabilization Act of 2025
  - Reverses the latest round of Medicare payment cuts providing immediate financial relief to stabilize practices and preserve patient access
  - Provides an inflationary update to ensure payments in 2025 begin to reflect the rising costs of delivering care, a critical step toward sustainable reform



www.FixMedicareNow.Org

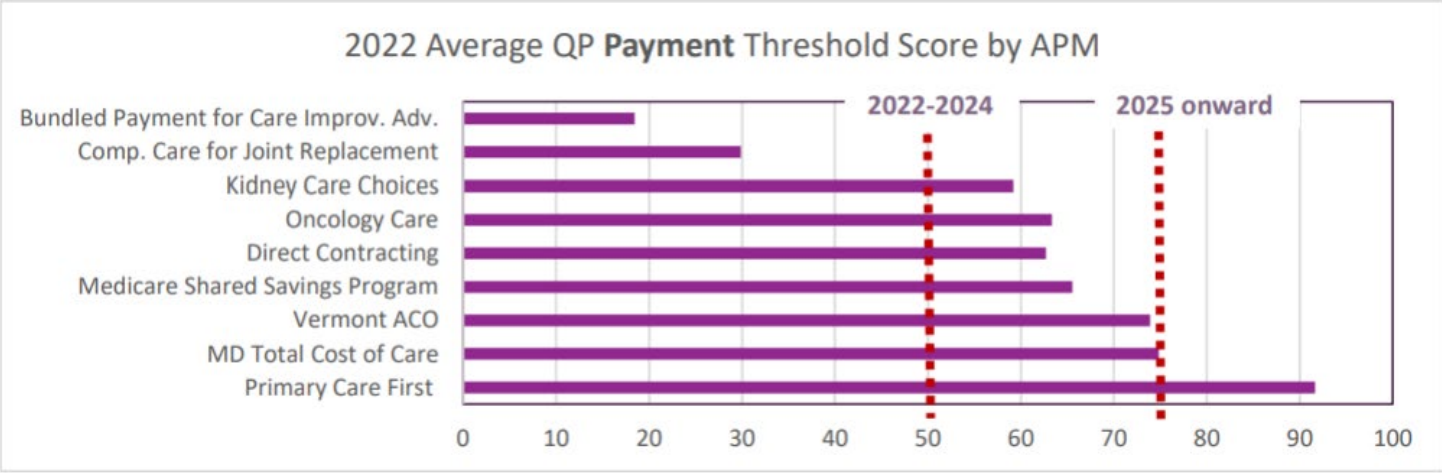
Alternative Payment Models

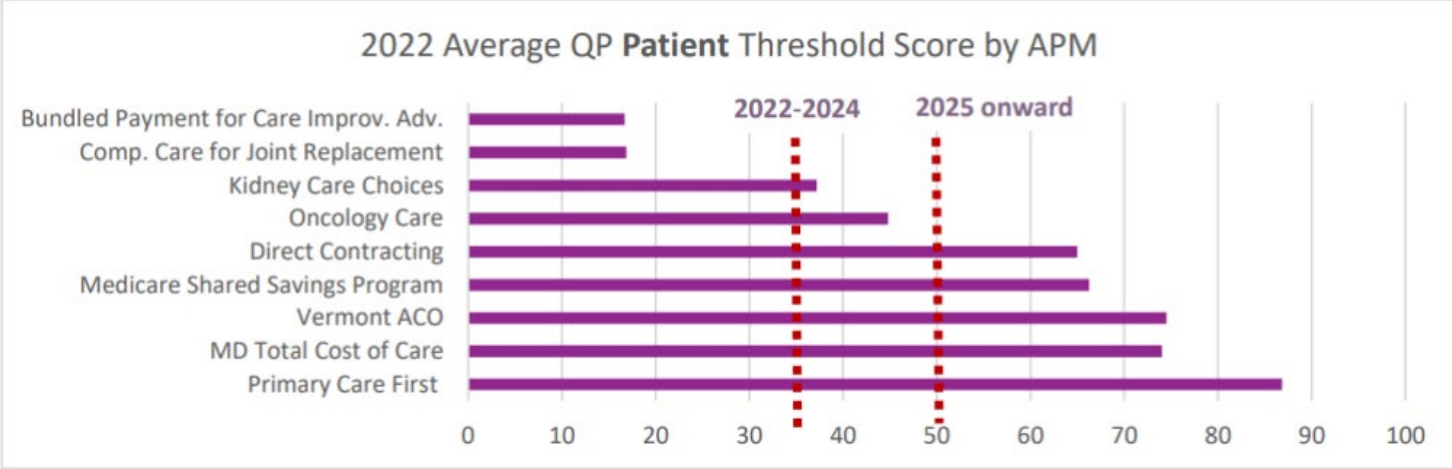
Alternative Payment Models (APMs)

- Qualifying APM Participants (QPs) in advanced APMs are exempt from the Merit-based Incentive Payment System (MIPS) and receive incentive payments:
  - 5% incentive payment for performance years 2017-2022
  - 3.5% incentive payment for performance year 2023
  - 1.88% incentive payment for performance year 2024
  - 0.5% higher conversion factor update (0.75% annual update) than everyone else (0.25% annual update) for performance years 2024 and beyond
- Under current law, incentive payments expired in 2025 and the QP threshold increased from 50% to 75% of Medicare part B payments or 35% to 50% of Medicare patients through the APM entity

APM Changes

- On March 12, 2025, the Centers for Medicare and Medicaid Innovation (CMMI) announced it was ending the following models early by Dec. 31, 2025:
  - Maryland Total Cost of Care (MD expected to transition to AHEAD model)
  - Primary Care First
  - ESRD Treatment Choices (will propose termination through rulemaking)
  - Making Care Primary
- CMS proposed changes to the mandatory Transforming Episode Accountability Model (TEAM) that begins in 2026
- Big picture: Many physicians, especially specialists and those in rural areas, lack access to APMs.





AMA Advocacy

- APMs have a successful track record of improving health outcomes and reducing costs. Extending APM incentives and broadening model availability will promote patient-centered care while maintaining provider choice and reward providers for improving patient health rather than for the volume of services provided.
- AMA urged Congress to support H.R. 786, the Preserving Patient Access to Accountable Care Act, bipartisan legislation that extends the APM incentive payments at 3.35% for the 2025 performance period and delays the QP threshold increase
- AMA joined a coalition of stakeholders urging Congress to extend Medicare's advanced APM incentive payments and stop the drastic QP threshold increase
- AMA joined a coalition of stakeholders urging MedPAC to stress the importance of continuing APM incentives in its June 2025 Report to Congress

Telehealth

Telehealth

- Congress extended telehealth flexibilities in Medicare **through Sept. 30, 2025,** in the CR
- On Feb. 7, AMA urged CMS to add the CPT audio-video and audio-only telehealth codes to the Medicare Telehealth List
  - "Each of the services in this code family is a substitute for an in-person office visit service but is provided via audio-only or audio-video telecommunications. As office visits are specifically defined as "telehealth services" in § 1834(m), these services should be added to the Medicare Telehealth List on a permanent basis."

Medicare Advantage

2026 Payment for MA Plans

- CMS finalized a **5.06% increase** or over $25 billion for MA plans in the CY 2026 Final Rate Announcement
    - AMA press statement on Advance Notice in January: “So, while MA plans receive an increase beyond the expected health care inflation rate, Congress not only failed to provide a physician payment update but allowed a new round of cuts at the end of the lame duck. It's unbelievable they're giving insurance companies that had record profits an increase while at the same time cutting payment to physician practices that are struggling to survive. This contrast highlights the urgent need for Congress to prioritize linking payment to physician practices to the cost of providing care. Otherwise, with or without MA plans, patient access will suffer if physicians close their practices. A new Congress is meeting —it’s time for a new approach to physician payment reform.”

2026 MA & Part D Final Rule Key Takeaways

- CMS finalized several MA reforms including prior authorization related updates, such as requiring MA plans to honor inpatient prior authorization approvals through discharge and applying appeal rights to decisions made during ongoing treatment.
- CMS also finalized guardrails for Special Supplemental Benefits for the Chronically Ill (SSBCI), as well as policies to improve the experience for dual-eligible enrollees.
- However, CMS declined to finalize several key AMA backed proposals, including:
  - Expanded Part D coverage of anti-obesity medications,
  - Expanded guardrails for augmented intelligence,
  - Utilization management reforms aimed at bolstering transparency,
  - Improving the Medicare Plan Finder, and
  - Agent/broker oversight

MedPAC March 2025 Report to Congress

- From 2018 to 2024, the share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent to 54 percent.
- MedPAC estimates that Medicare will spend 20 percent more for MA enrollees in 2025 than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $84 billion.
  - Favorable selection
  - Risk adjustment and coding intensity
- Higher MA spending increases Part B premiums for all beneficiaries, including those in FFS Medicare

Regulatory Relief

Executive Orders and Memos

- On Jan. 31, President Trump signed Executive Order 14192 declaring “the policy of the executive branch” to be that federal agencies should “alleviate unnecessary regulatory burdens placed on the American people” and directing agencies to identify 10 existing regulations to be repealed whenever one is publicly proposed for notice and comment.
- On Feb. 19, President Trump signed Executive Order 14219 directing agencies to “initiate a process to review all regulations” and identify regulations that, among other things, “impose undue burdens on small businesses and impede private enterprise and entrepreneurship.”
- On April 9, the President issued a Presidential Memorandum directing agencies to identify unlawful and potentially unlawful regulations and take immediate steps to effectuate the repeal of any regulation, or the portion of any regulation, that clearly exceeds the agency’s statutory authority or is otherwise unlawful. “The repeal of each unlawful regulation shall be accompanied by a brief statement of the reasons that the “good cause” exception applies.”

AMA Advocacy and Agency Requests for Input

- On Feb. 24, the AMA wrote to CMS outlining the opportunities for regulatory relief in the Merit-based Incentive Payment System (MIPS).
- The Department of Justice (DOJ) Anticompetitive Regulations Task Force is seeking comment by May 26 on “laws and regulations that make it more difficult for businesses to compete effectively, especially in markets that have the greatest impact on American households,” including in health care.
- The White House Office of Management and Budget (OMB) issued a request for information with a 30-day comment deadline about “regulations that are unnecessary, unlawful, unduly burdensome, or unsound” and proposals to rescind or replace those regulations.
- CMS issued an RFI seeking input on opportunities to streamline regulations and reduce burdens on physicians and QHPs.

New Administration

Administrator Oz: Vision for CMS

Empowering the American people with personalized solutions they can better manage their health and navigate the complex health care system. As a first step, CMS will implement the President's Executive Order on Transparency to give Americans the information they need about costs.

Equipping health care providers with better information about the patients they serve and holding them accountable for health outcomes, rather than unnecessary paperwork that distracts them from their mission. For example, CMS will work to streamline access to life saving treatments.

Identifying and eliminating fraud, waste, and abuse to stop unscrupulous people who are stealing from vulnerable patients and taxpayers.

Shifting the paradigm for health care from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management. For example, CMS operates many programs that can be used to focused on improving holistic health outcomes.

AMA letter to congratulate Dr. Oz and offer to be a resource

Physicians' powerful ally in patient care

Members Present: Thomas Weida, MD (Chair), Gregory DeMeo, MD (Vice Chair), Margie Andreae, MD, Anita Arnold, DO, Leisha R. Eiten, AuD, John Heiner, MD, Omar Hussain, DO, M. Douglas Leahy, MD, Swati Mehrotra, MD, Anne Miller, MD, Howard Rogers, MD, Sanjay A. Samy, MD, Christopher Senkowski, MD, Scott Sperling, PsyD, Mark Villa, MD, David Yankura, MD, Robert Zwolak, MD

I. Welcome and Introduction to the Research Subcommittee

Doctor Weida welcomed all members to the Research Subcommittee and everyone introduced themselves.

II. Review of February 24th and March 13th Research Subcommittee Conference Call Reports

The Research Subcommittee reports from the February 24th and March 13th conference calls included in Tab 12 agenda materials were approved without modification.

III. Standard RUC Survey

On the March 13th Research Subcommittee conference call, AMA staff demonstrated the RUC online survey tool to the Research Subcommittee. The Subcommittee was solicited for feedback at that time and the following issues were identified for discussion at the April 2025 in-person meeting.

a. Full CPT Language Review Attestation

Several Subcommittee members had suggested that an attestation question should be incorporated into the standard RUC survey template, requiring respondents to confirm their review of the full CPT guidelines. Currently this question is added on a case-by-case basis. For example, all of the recent E/M surveys had this question included.

The Subcommittee considered this issue during the April 2025 meeting and determined to maintain the current process without modification. Currently, the RUC requires RUC surveys to include the full CPT language for each survey code under review, including CPT introductory guidelines, long descriptors and parentheticals. An CPT guideline review attestation question can be added by societies on a case-by-case basis.

b. Practice Demographic Question Review

A Subcommittee member had inquired whether the urban/rural/suburban and single specialty/ multispecialty practice setting questions should be retained. A proposal was made to consider the elimination of these questions. During the April 2025 discussion, Subcommittee members concurred that it would be appropriate to delete these questions for all standard RUC survey templates in order to reduce survey fatigue. Also, Subcommittee members noted that these data are not currently summarized in the RUC summary of recommendation form (SOR) or the RUC summary spreadsheet.

The Research Subcommittee agreed to delete the following questions from all standard RUC Survey templates.

~~**Primary geographic practice setting:** ☐ Rural ☐ Suburban ☐ Urban~~

~~**Primary type of practice:** ☐ Solo practice~~
~~☐ Single specialty group~~
~~☐ Multispecialty group~~
~~☐ Medical school faculty practice plan~~

It was noted that societies could propose to Research to add these questions back on a case-by-case basis if they feel these questions are warranted for a specific survey.

c. Intensity/Complexity Response Options

During the April 2024 RUC New Business discussion, a RUC member inquired about the intensity/complexity survey questions and the use of "identical" as the midpoint of the five-point comparison scale included in the standard RUC survey templates or if the midpoint should instead state "similar" intensity/complexity compared to the key reference services. The inquiry was based on a concern that survey respondents may be reluctant to select the term "identical" as this implies an exactness. The RUC referred this item for consideration by the Research Subcommittee at the September 2024 meeting. The Subcommittee discussed this issue in September 2024 though did not come to a decision so tabled the discussion for the future.

During the April 2025 meeting, the Subcommittee noted that the RUC intensity survey question measures intensity relative to the KRS using two degrees of separation with neutral where neutral is "identical." Several Subcommittee members expressed support for switching away from "identical", which many concurred was too exact. Many members expressed support for the term "same". A Subcommittee member noted that they spoke with several survey experts at their health system and the survey experts recommended for the Subcommittee to consider a pilot test and also recommended the use of the term "same". The Subcommittee determined that a pilot test would not be necessary at this time.

The Research Subcommittee agreed to update all standard RUC Survey templates as follows for the survey intensity and complexity questions. Subcommittee members also asked AMA RUC staff to track the impact of this decision as new survey data become available and report back after one year of data is available.

Question 3

Compare INTENSITY COMPONENTS of the survey code(s) relative to the corresponding reference code(s) you selected in Question 1. Using your expertise, consider how each survey code compares directly to the corresponding reference code. For example, if you find the mental effort and judgment for the survey code is **the same** ~~**identical**~~ when compared to the corresponding reference code you chose in Question 1, select "**same** ~~**identical**~~" in the dropdown box below.

Mental effort and judgment

Survey Code XXXX1
Relative to

Selected Reference Code [Pipe Code #]

• The range of possible diagnoses and/or management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed • Urgency of medical decision making	Much Less Somewhat Less **Same ~~Identical~~** Somewhat More Much More

Technical skill/physical effort

Survey Code XXXX1
Relative to
Selected Reference Code [Pipe Code #]

Technical skill required	Much Less Somewhat Less **Same ~~Identical~~** Somewhat More Much More
Physical effort required	Much Less Somewhat Less **Same ~~Identical~~** Somewhat More Much More

Psychological stress

Survey Code XXXX1
Relative to
Selected Reference Code [Pipe Code #]

• The risk of significant complications, morbidity and/or mortality • Outcome depends on skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	Much Less Somewhat Less **Same ~~Identical~~** Somewhat More Much More

Question 4

Compare OVERALL intensity/complexity of all physician work you perform for the survey code(s) relative to the corresponding reference code(s) you selected in Question 1. Using your expertise, consider how each survey code compares directly to the corresponding reference code.

To view the descriptor for the survey code(s) and reference code(s), place your cursor over the symbol located next to the code number.

Survey Code XXXX1
Relative to

Overall Intensity/Complexity of all physician work you perform for the service	Much Less Somewhat Less **Same ~~Identical~~** Somewhat More Much More

IV. Maternity Care Services RUC Survey Customization Requests
American College of Obstetricians and Gynecologists

The CPT Maternity Care Services (MCS) workgroup submitted a code change application (CCA) for the May 2025 CPT meeting to dramatically restructure how maternity care services will be reported in CPT. In order to prepare for the large (20 CPT codes), multispecialty RUC survey, the American College of Obstetricians and Gynecologists (ACOG) submitted a request to consider changes to the RUC survey template and new vignettes for several codes that are not anticipated to be modified by the Panel.

ACOG noted that the surveying specialties will include the new language on the RUC survey template and require the surveyee to attest to reading the language prior to starting the RUC survey. In addition to the pre survey attestation, the specialties would like permission to modify the standard survey templates to include the related guideline language throughout the survey tool. AMA staff confirmed that these changes do not require Research Subcommittee approval.

Separately, ACOG requested approval to use the 2022 Hospital Inpatient/Observation Services survey template for the four new XXX, per calendar date, labor management CPT Codes. Several Subcommittee members noted that they were not necessarily opposed to the concept, but would be more comfortable to review this request once the full CPT language is approved and available for additional context. Subcommittee members also noted that it would be helpful to be able to compare the updated CPT language to the hospital/observation visit codes as well. The Subcommittee requested for ACOG to submit an updated request for the Subcommittee's next conference call which will be held in mid-May after the final modified CPT language becomes available. ACOG staff and AMA RUC staff will start collaborating on the proposed template in advance for the May Research call.

ACOG requested Research approval of the following maternity care services CPT code vignettes. These codes do not have any proposed long descriptor revisions being considered by the CPT Editorial Panel. They instead are only proposed to be relocated in the CPT Book. **The Research Subcommittee reviewed and approved the following vignettes without modification.**

59320 Cerclage of cervix, during pregnancy; vaginal
Research-approved vignette: A 28-year-old gravida 2, para 1 at 20 weeks and 2 days has shortened cervix. Vaginal cerclage is performed.

59325 Cerclage of cervix, during pregnancy; abdominal
Research-approved vignette: A 35-year-old gravida 4, para 0 at 12 weeks and 6 days has cervical insufficiency. Abdominal cerclage is performed.

59871 Removal of cerclage suture under anesthesia (other than local)
Research-approved vignette: A 28-year-old gravida 2, para 1 at 36 weeks presents for removal of cerclage suture.

59414 Delivery of placenta (separate procedure)
Research-approved vignette: A 31-year old, gravida 3, para 2 requires delivery of placenta (separate procedure).

59160 Curettage, postpartum
Research-approved vignette: A 23-year-old gravida 2, para 2 has postpartum bleeding and retained products of conception. Postpartum curettage is performed.

AMA/Specialty Society RVS Update Committee **Tab 13**
Practice Expense Subcommittee
April 23, 2025

Members Present: Scott Manaker, MD, PhD (Chair), Jennifer Aloff, MD, Amy Aronsky, DO, Gregory Barkley, MD, Luke Barré, MD, Michael Booker, MD, Eileen Brewer, MD, Neal Cohen, MD, David Han, MD (Vice Chair), Peter Hollmann, MD, Thomas Kintanar, MD, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, and Timothy Swan, MD (CPT Resource)

I. New Business

The Practice Expense (PE) Subcommittee considered Tab 7 *Transoral Oropharyngeal Procedures* and noted that the components of EQ137 *instrument pack, basic ($500-$1499)* and EQ138 *instrument pack, medium ($1500 and up)* are not defined. The medium instrument pack EQ138 is included as a direct input for current CPT code 42808 and the society recommended including it for the revised code 42808 *Excision or destruction of lesion of pharynx, without magnification, any method.* The PE Subcommittee agreed with the recommendation but expressed the need to understand the background related to the formation of these packs. **The Subcommittee agreed that AMA staff will research the issue of EQ137 and EQ138 instrument packs to share the history regarding how these packs were developed.**

Practice Expense Recommendations for CPT 2027

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

Tab	Title	PE Input Changes	Consent Calendar
4	Ablation Therapy – Bone Tumors	No Direct PE Inputs recommended – Facility-only Add-on service (209XX) No Survey (20982, 20983)	X
5	Computer Assisted Surgical Navigation	No Direct PE Inputs recommended – Facility-only Add-on service (20985) No Survey (27130, 27446, 27447)	X
6	Division of Median Arcuate Ligament	Standard 90-day global inputs recommended	X
7	Transoral Oropharyngeal Procedures	Modifications	
8	Unattended Sleep Testing	Modifications	
9	Autonomic Function Testing	Modifications	

Tab	Title	PE Input Changes	Consent Calendar
10	Laser Treatment for Psoriasis	Maintain CMS inputs	
11	Stereotactic Computer-Assisted Volumetric Navigational Procedures	(1) Modification	

Members Present: Doctors Amr Abouleish (Chair), Gregory Nicola (Vice Chair), Dale Blasier, Audrey Chun, Jeffrey Edelstein, Alexandra Flamm, Harlivleen Gill, MBA, RDN, Martha Gray, Gregory Harris, Gwenn Jackson, Kevin Kerber, James Shoemaker, Clarice Sinn, Michael Sutherland, John Thompson, G. Edward Vates and Timothy Swan (CPT Resource)

I. Relativity Assessment Overview

AMA staff provided a brief overview on where to find the Relativity Assessment Workgroup Issues and New Technology/Services resources on the RUC Collaboration site.

II. Review Action Plans

CMS Other Source Utilization

Telehealth Consultations (G0407, G0408, G0425, G0426, G0427)

In October 2020, the RUC identified code G0407 and G0408 as a CMS/Other sourced code with 2019 estimated Medicare utilization over 20,000. The Workgroup requested action plans be reviewed for these services at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or the G code should be surveyed. At the December 2020 RAW meeting, the Workgroup recommended to postpone until April 2021 RAW for input from ANA and APA. In April 2021, the RUC recommended these services be reviewed in 2 years (April 2023) after additional data are available. Second, there should be a CPT Assistant article, if appropriate, or other CMS education regarding who should be reporting these services. The RAW also informed CMS of possible misreporting of these services. Based on the Medicare Provider Utilization and Payment Data Physician and Other Supplier PUF CY 2018 data, seven to eight individual Nurse Practitioners account for approximately 50% of G0407 and G0408 services provided.

In April 2022, code G0425 was also identified as a CMS/Other sourced code with 2020 Medicare utilization over 20,000. Following the January 2023 RUC discussion on G0425-G0427, which the RUC determined that CMS should replace the G codes once the CPT 2025 telemedicine codes are available. The RAW will review G0407 and G0408 with G0425-G0427 in April 2029 after three years of data are available. If there is no action on these services for CPT 2025, the RAW should review them in two years (April 2025). Since CMS did not delete these services for 2025, they are on the agenda for discussion and review of the action plan submitted by AAN, ACP, ANA, APA (psychiatry) and SCCM.

The Workgroup reviewed these action plans and determined that G0407, G0408, G0425, G0426, G0427 be reviewed in April 2028 after three years of additional data are available.

High Volume Growth

Manual Microdissection (88381)

In April 2022, the Workgroup identified CPT code 88381 as having Medicare utilization of 10,000 or more that increased by at least 100% from 2015 through 2020. The Workgroup requested that the specialty societies submit an action plan for September 2022. In September 2022, the Workgroup recommended reviewing after 3 years after additional data available (2021, 2022 & 2023 data). **In**

April 2025, the Workgroup reviewed the action plan and determined to remove CPT code 88381 from the high volume screen because the growth is appropriate as microdissection services are utilized with molecular codes, multianalyte assays with algorithmic analyses (MAAA) and proprietary laboratory analyses (PLA) codes, thus driving utilization. The Workgroup also noted that the physician work is the same for the various tumors that are resected and does not change from one type of malignancy to another.

Near Infrared Dual Imaging (0507T)
In April 2022, the Workgroup identified Category III code 0507T with 2020 Medicare utilization over 1,000. The Workgroup requested an action plan for September 2022. In September 2022, the Workgroup recommended that this service be reviewed in 3 years to see if this service meets CPT criteria for a Category I code.

In April 2025, the Workgroup reviewed the action plan and agreed with the specialty societies that 0507T may not meet the criteria to be converted to a Category I CPT code due to a lack of peer-reviewed literature and lack of widespread use, noting that two providers make up over 50% of the utilization. **The Workgroup recommends removing CPT code 0507T from the Category III high volume screen and noted that the specialties could submit a CCA for a Category I code when it meets those criteria.**

New Technology/New Services Codes
In 2005, the AMA RUC began the process of flagging services that represent new technology or new services as they were presented to the Committee. This April, the Relativity Assessment Workgroup continued review of CPT 2021 codes that were flagged at the April 2019, October 2019, and January 2020 RUC meetings, with three years of available Medicare claims data (2021, 2022 and 2023).

The Workgroup reviewed the action plans and recommends the following:

CPT Code	Issue	Workgroup Recommendation
33361 33362 33363 33364 33365 33366	Transcatheter Aortic Valve Replacement (TAVR) *Also on DNU flag review*	**Survey for September 2025**. The patient population has changed on who is receiving these services and it is no longer the sickest, most complicated patients, but will be available to more candidates and these services may be used to treat aortic regurgitation. The Workgroup indicated if National Coverage Determinations (NCDs) for these services having a co-surgery designation, the specialties could submit a CCA if any code descriptor changes are necessary.
33418 33419	Transcatheter Mitral Valve Repair	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33858 (f) 33859 (f) 33863 (f) 33864 (f) 33866	Aortic Graft Procedures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33995 33997	Percutaneous Ventricular Assist Device Insertion	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. These services have extremely low volume with minimal growth.

36465 36466 36482 36483	Treatment of Incompetent Veins	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. The Workgroup noted that these services include high-cost supply items *SD324 Varithena (foam)* for codes 36465 and 36466 and *SD323 Venaseal (glue)* for 36482, which the RUC continues to request that CMS price separately.
36473 36474	Mechanochemical (MOCA) Vein Ablation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
36475 36476 36478 36479	Endovenous Ablation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
55880	Transrectal High Intensity Focused US Prostate Ablation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
57465	Computer-Aided Mapping of Cervix Uteri	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
66982 66984 66987 66988 66989 66991	Cataract Removal with Drainage Device Insertion *Also on DNU flag review*	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. Newer services 66989 and 66991 were being performed long before the Category I codes were established, therefore there was no learning curve or difference in physician work now as there were when these codes were established. Utilization is also stable.
69705 69706	Dilation of Eustachian Tube	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
71271	Screening CT of Thorax	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
77061 77062 77063	Breast Tomosynthesis	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. CMS maintains 77061 and 77062 as "Invalid", instead G0279 should be reported for unilateral or bilateral diagnostic digital breast tomosynthesis for Medicare.
77520 77522 77523 77525	Proton Beam Treatment Delivery (PE Only)	Remove from list. These services were surveyed and RUC recommendations provided. CMS maintains as contractor priced.
92227 92228 92229	Remote Retinal Imaging	**Review in 3 years (April 2028)** after additional data is available. Specifically review practice expense and assess if the equipment is typical for the variety of providers providing this service.
92517 92518 92519	Vestibular Evoked Myogenic Potential (VEMP) Testing	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

93241 93242 93243 93244 93245 93246 93247 93248	External Extended ECG Monitoring	**Review in 3 years (April 2028)** after additional data is available. Specifically review if the practice expense inputs have changed.
98970 98971 98972	Online Digital Evaluation Service (e-Visit) - QHP	**Refer to CPT Assistant** to develop an article to inform who should be reporting QHP codes 98970-98972 versus the physician codes 99421-99423. The Workgroup questioned why the 2023 Medicare claims data indicate the QHP codes are primarily performed by family medicine, internal medicine and gastroenterology. **Review again three years after the CPT Assistant article is published.**
99202 99203 99204 99205 99211 99212 99213 99214 99215	Office Visits	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
99417 G2212	Prolonged Services - on the date of an E/M	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
99421 99422 99423	Online Digital Evaluation Service (e-Visit) - Physician	**Refer to CPT Assistant** to develop an article to inform who should be reporting QHP codes 98970-98972 versus the physician codes 99421-99423. The Workgroup questioned why the 2023 Medicare claims data indicate the QHP codes are primarily performed by family medicine, internal medicine and gastroenterology. **Review again three years after the CPT Assistant article is published.**
99451 99452	Interprofessional Internet Consultation	Remove from list, no demonstrated technology diffusion that impacts work or practice expense. The Workgroup noted that these services will be caught by other RUC screens, such has high volume growth, if that threshold arises.

RUC Flag Review

At the January 2025 meeting the Relativity Assessment Workgroup determined that it should reexamine the other specific flagged codes that are currently flagged in the RUC database, in detail by reviewing an action plan from the specialty societies. The Workgroup will spread this review over the next three meetings, first looking at the top 1/3 of codes with the highest Medicare utilization.

The Workgroup reviewed action plans to determine if the top DNU specific flagged codes should be resurveyed, revised at CPT, maintained with the flag or the flag removed. The goal will be to find a way to resolve the issue that led to the flag, if possible. The Workgroup noted if a code is on the new technology/new services list already scheduled for review, that those codes be maintained on that list and address the new technology/new service and DNU flag at the same time.

The Workgroup reviewed action plans for the following and recommends:

CPT Code	Issue	Workgroup Recommendation
31605 31610	Tracheostomy	Maintain as flagged do not use to validate physician work.
33361 **33362** **33363** **33364** **33365** **33366**	Transcatheter Aortic Valve Replacement (TAVR) *Also on new tech/new services screen*	**Survey for September 2025**. The patient population has changed on who is receiving these services and it is no longer the sickest, most complicated patients, but will be available to more candidates and these services may be used to treat aortic regurgitation. The Workgroup indicated if National Coverage Determinations (NCDs) for these services having a co-surgery designation, the specialties could submit a CCA if any code descriptors are necessary.
43241 43251	Esophagogastro-duodenoscopy	Maintain as flagged do not use to validate physician work.
43284 43285	Esophageal Sphincter Augmentation	Maintain as flagged do not use to validate physician work. Medicare Utilization is less than 100, may not be able to obtain a valid survey.
64400 64405 (f)	Injection Anesthetic Agent	**Survey for September 2025 with family of services**. In 2018 for CPT 2020, the RUC flagged 64400 because the RUC recommended work RVU of 1.00 was based on the 25th percentile work RVU of the top performing specialty, neurology. CMS did not accept the RUC recommendation and valued 64400 lower at 0.75.
66984 66987 66991	Cataract Removal with Insertion of Intraocular Lens Prosthesis *Also on new tech/new services screen*	Maintain as flagged do not use to validate physician work. The survey methodology was used to avoid rank order anomalies within the family of services.
67255	Scleral Reinforcement	Maintain as flagged do not use to validate physician work. 2023 Medicare utilization is low (518) and not performed by many physicians.
67505	Retrobulbar Injection	Maintain as flagged do not use to validate physician work. 2023 Medicare utilization is low (72) and not performed by many physicians.

91200	Liver Elastography	**Remove flag.** This service has been surveyed three times, 2014, 2015 and 2020. In 2021, The RUC recommended to flag CPT code 91200 as "do not use to validate for physician work" since the survey respondents may have overestimated the intra-service time due in part to the language in the vignette. The Workgroup determined there is no evidence that the code is misvalued and the flag should be removed.
97010 (f) 97012 97014 97016 97018 97022 97024 (f) 97026 (f) 97028 (f)	Physical Medicine and Rehabilitation – Supervised Modalities	Maintain as flagged do not use to validate physician work. In 2017, the supervised modalities were marked "Do not use to validate for work" as the current database time and survey time estimates were not accepted by the RUC HCPAC Review Board as credible.

III. 2025 Reiteration of Screens – based on 2023 Medicare Utilization

Site of Service Anomalies

Outpatient Setting but Includes Hospital Visits
Five codes were identified as a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. Codes 23472, 27130, 27447, 44970 and 63047 were identified. Codes identified via the site of service anomaly screen go straight to the level of interest form for survey at the next meeting. The Workgroup also worked with the specialty societies to identify the families associated with these five services. **The Workgroup recommends codes 23470, 23472, 27130, 27446, 27447, 44950, 44955, 44960, 44970, 63045, 63046, 63047 and 63048 be placed on the LOI and surveyed for September 2025.**

CMS/Other Source – Medicare utilization over 20,000
The Workgroup identified five codes that have CMS/Other source and 2023 Medicare utilization over 20,000. **The Workgroup requests that action plans be submitted for codes 73201, G0270, G0453, G2083, and G3002 at the September 2025 meeting to determine how to address these services and if current CPT codes exist to report these services described by the G code, new CPT codes should be created, or the G code should be surveyed.**

Harvard Valued – Medicare utilization over 30,000
The Workgroup identified two Harvard-valued services with 2023 Medicare utilization over 30,000. **The Workgroup requests that action plans be submitted for codes 31525 and 36248 for review by the Relativity Assessment Workgroup in September 2025.**

High Volume Growth
The Workgroup identified nine codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. **The Workgroup requests that the specialty societies submit an action plan for codes 31525, 31627, 33340, 36465, 65820, 92978, 93355, 95251 and 96127 for September 2025.**

Surveyed by one specialty and now performed by a different specialty

The Workgroup identified nine codes where the top two dominant specialties performing services based on 2023 Medicare utilization more than 10,000 and where the top specialty performing over 50% of the Medicare claims did not survey the service or the top two specialties did not survey the service. **The Workgroup requests action plans for codes 16020, 25605, 62368, 64505, 73580, 77261, 86077, 95144 and 96521 for September 2025.**

Contractor-Priced High Volume

The Workgroup identified one code with 2023 Medicare utilization over 10,000 and Medicare status of "C" contractor priced. **The Workgroup requests an action plan for G0340 for September 2025.**

Category III High Volume

The Workgroup identified seven Category III codes with 2023 Medicare utilization over 1,000. The Workgroup noted that once identified, action plans are requested for the Category III high volume codes. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. **The Workgroup requests action plans for codes 0207T, 0480T, 0486T, 0512T, 0627T, 0640T and 0753T for September 2025.**

Work Neutrality (CPT 2023)

The Workgroup identified four issues for codes that were reviewed for CPT 2023 (April 2021, October 2021, and January 2022) that have more than 10% increase in work RVUs from what was projected. **The Workgroup requests action plans for Cardiac Ablation (93653-93657, 93613, 93621 and 93662), Orthoptic Training (92065-92066), Percutaneous Nephrolithotomy (50080, 50081 and 50432) and Neuromuscular Ultrasound (76881-76883) for September 2025.**

Services Reported Together 75% or More

The Workgroup identified two code pairs for services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in 2023 Medicare claims data and/or contained at least one ZZZ global service were removed. **The Workgroup requests action plans for September 2025 to determine if specific code bundling solutions should occur for the following code pairs.**

CPT Code 1	CPT Code 2	Percent Billed Together
55874	55876	75.1%
63015	22600	83.2%

IV. Discussion of Potential New Screens

The Workgroup chair opened up the discussion for examination of two possible new screens:

One possible new screen may be codes that have not been reviewed in the past 20 years with Medicare Utilization over 1 million. **AMA staff will run data, and the Workgroup will review a list of these codes at the next meeting.**

Another possible screen is revisiting the IWPUT screen. The Workgroup last reviewed the High IWPUT screen in 2008. The High IWPUT screen was based on services with a total Medicare utilization of 1,000 or more with an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in the identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate.

In September 2025, the Workgroup will review codes with an IWPUT greater than 0.14 and determine the next steps.

VI. Informational Items

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

AMA/Specialty Society RVS Update Committee **Tab 15**
Administrative Subcommittee
April 24, 2025

Members Present: John Proctor, MD (Chair), Matthew Grierson, MD (Vice Chair), Megan Adamson, MD, Kris Anderson, DC, MS, James Blankenship, MD, Allen Dennis, MD, Daniel Duzan, MD, Bradley Fox, MD, Patrick Godbey, MD, Kristopher Kimmell, MD, Timothy Laing, MD, Lance Manning, MD, Paul Martin, DO, John McAllister, MD, Lauren Nicola, MD, Noah Raizman, MD, Thomas Turk, MD, Korinne Van Keuren, DNP, MS, RN and James Waldorf, MD.

I. Welcome and Introduction to the Administrative Subcommittee

Doctor Proctor welcomed all members to the Administrative Subcommittee.

II. Administrative Subcommittee Responsibilities

Doctor Proctor and AMA staff, Susan Clark, provided an overview of the resources available on the RUC Collaboration site and the responsibilities of the Administrative Subcommittee. The overview included reviewing the following:

- RUC Structure and Functions
- Rules and Procedures
- RUC Confidentiality Agreement
- RUC Anti-Lobbying Policy
- Financial Disclosure Policies
    - Statement of Compliance
    - Financial Disclosure for Presenters
    - Financial Disclosure Review Process
- RUC Vendor/Company Attestation
- Rotating Seat Policies and Election Rules
- Annotated List of RUC Actions

Professional Liability Insurance Workgroup Report
Thursday, April 24, 2025

Members Present: Bradley Marple, MD (Chair), Gregory Barkley, MD (Vice Chair), Luke Barré, MD, Gregory DeMeo, DO, Daniel Duzan, MD, Jonathan Feibel, MD, Patrick Godbey, MD, Jonathan Kiechle, MD, Thomas Kintanar, MD, Doug Leahy, MD, Lisa Price, MD, Christopher Senkowski, MD, Clarice Sinn, DO, Nelda Spyres, LCSW, Mark Villa, MD, Mary Walsh Sterup, OTR/L

I. Welcome and Introduction to the Professional Liability Insurance Workgroup

Doctor Marple welcomed all members to the Professional Liability Insurance Workgroup and everyone introduced themselves.

II. Overview of RBRVS Professional Liability Insurance Methodology

Doctor Marple and AMA staff, Mike Morrow, provided an overview of the responsibilities of the PLI Workgroup and CMS' PLI methodology. Doctor Marple noted that the PLI Workgroup is primarily charged with review and recommendation of refinement to Medicare's PLI relative value methodology. He also noted that CMS only reassesses the specialty liability insurance risk premiums that are the main input in the PLI formula once every 3 years, with the next one occurring in the upcoming proposed rule this summer. Therefore, the Workgroup will also have a meeting during the NPRM comment period. At that meeting, the Workgroup would review any proposed policy from the NPRM and provide general guidance on how to respond.

Mike Morrow separately walked the Workgroup through how the PLI RVU is calculated for an example CPT code and gave an overview of CMS' PLI methodology in general. He also provided an overview of CMS' policy to have single-specialty PLI risk premium overrides for very low volume services. CMS has a list of approximately 2,000 low volume CPT codes that are subject to this policy currently. The Workgroup will review potential additions to this list at its summer meeting.

Physician Practice Information Survey

Carol Kane, PhD
Director, Economic and Health Policy Research

Sherry Smith, MS, CPA
Director, Physician Payment Policy

Centers for Medicare & Medicaid Services (CMS) Practice Expense Relative Value Unit (RVU) Methodology

Complex methodology, relying on the following data sources:

- Direct practice cost estimates at individual code level
- Bureau of Labor Statistics for clinical staff compensation
- Pricing studies for medical supplies and equipment
- Medicare claims data
- Work relative value units
- The American Medical Association's (AMA's) practice cost survey data and supplemental survey data

Medicare Economic Index (MEI)

- The MEI is a measure of practice cost inflation that was developed in 1975 to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates.
- The MEI distribution of physician work, practice expense and professional liability insurance (PLI) is used to determine the weights of these relative value pools.

Medicare Economic Index (MEI) - History

	1975-1992	1993	1996	2000	Currently Used – 2006 Data	Updated CMS MEI Weights (Postponed)
Physician Work	60.0%	54.2%	54.5%	52.5%	50.9%	47.5%*
Practice Expense (PE)	40.0%	41.0%	42.4%	43.7%	44.8%	51.1%*
Professional Liability Insurance (PLI)	(incl with PE)	4.8%	3.2%	3.9%	4.3%	1.3%

*AMA Comment: New CMS MEI is flawed because it excludes hospital-based physicians.

AMA Socioeconomic Monitoring System (SMS)

- The SMS, an annual phone survey of 4,000 physicians, was conducted from the early 1980s through 1999.
- SMS surveyed physician practice arrangements, managed care involvement, income and expenses, and hours and weeks of work.
- SMS utilized for MEI – supported the 60% work, 40% PE used through 1992.
- Core 1989 SMS Survey used to establish MEI for the 1993 Resource Based Relative Value Scale (RBRVS).
- SMS Data used to update MEI in 1996 and 2000
- Resource-based PE RVUs in 1999 – SMS 1995-1999 data were utilized.

Physician Practice Information (PPI) Survey 2007/2008

- In 2010, CMS began a four-year transition to employ new practice expense data from the Physician Practice Information (PPI) Survey.
- Survey was administered by **dmr**kynetec via phone, fax, mail, and online.
- Jointly funded by CMS, AMA and national specialty societies.
- 2006 practice expense per hour was reported based on PPI data from 2,795 physicians.

Other PPI, Crosswalk, and Specialty Society Supplemental Surveys

- **dmr**kynetec also administered surveys for non-MD/DO health care professionals.
- CMS cross-walked data for 34 specialties to other like specialites.
- CMS does not utilize claims data from Nurse Practitioners or Physician Assistants in the current methodology because PE/Hour data were not available.
- Supplemental survey data implemented for Medical Oncology, Independent Diagnostic Testing Facilities (IDTFs) and Independent Labs.

AMA House of Delegates (HOD) Resolution

- In June 2019, the AMA HOD referred for decision a request for the reengagement in practice cost data collection

- The AMA Board of Trustees directed AMA staff to conduct physician interviews and a pilot study to determine the feasibility of a new data collection effort.

Physician Practice Interviews 2020 and 2022

- In early 2020, AMA staff interviewed financial experts representing various physician practice types to inform a contract for a larger interview process.
- The AMA retained Medscape to interview and pilot survey 50 physician practices in summer 2020. One key finding was that it was necessary to query the financial experts in the practice directly. Also advised to pause until after COVID impacts to practices.
- In 2022, the AMA interviewed an additional 20 larger physician practices and health systems, met with CMS and obtained budget approval to proceed with a 2023-2024 PPI Survey effort.

PPI Survey Development

- The AMA retained Mathematica and provided significant resources to design and administer a new PPI Survey in 2023-2024.
- The PPI survey was designed based on previous effort, CMS definitions, learnings from the interviews and pilot testing. Specialties were also provided with the opportunity to review and provide comment in late 2022.
- Mathematica pre-tested and piloted the survey prior to launch in summer 2023.

Example of a Table From the PPI

TABLE A. Physicians: ANNUAL Work RVUs, and ANNUAL Compensation, by specialty in [2022/2023]						
Part 1	Average # of physicians at the practice during [2022/2023]				Total ANNUAL COMPENSATION for ALL physicians	
Physician Specialty	1a. part-time *(less than [Y] hours per week)*	1b. full-time *(at least [Y] hours per week)*	2. Percent of time physicians billed in non-facility settings	5. Total ANNUAL work RVUs provided by ALL physicians	6a. Monetary compensation	6b. Benefits
[SPECIALTY]						
[SPECIALTY]						
TOTAL	*Total*	*Total*		*Total*	*Total*	*Total*

PPI Survey Support Letter – 170+ organizations

- More than 170 organizations signed a letter of support to share with all potential survey respondents. All state medical associations; more than 100 national medical specialty societies and other health care professional associations; American Group Medical Association; Medical Group Management Association; and the Association of American Medical Colleges all signed the letter.
- Nearly all these organizations sent out additional communications to support the effort in 2023-2024.

PPI Survey Incentives

- Small practices (i.e., fewer than 10 physicians) were offered $100 to complete survey.
- All survey respondents offered a complimentary one-year online subscription to the AMA's RBRVS DataManager.
- Tested offering $500 to medium sized practices and $1,000 to large practices. Incentives to larger practices were not effective, so was not extended.

PPI Survey Sample and Practice Information

- Practices were defined by Taxpayer Identification Numbers (TINs). Sampling using TINs aligns with available information in the Medicare Data on Provider Practice & Specialty (MD-PPAS). MD-PPAS includes physicians who have billed Medicare.
- Practice information from IQVIA's OneKey data was linked to MD-PPAS to find information on names and contact information of financial experts.
- IQVIA OneKey data used directly to select pediatric medicine sample.
- Sampling and weighting variables will be discussed in later slides.

PPI Survey Administration

- Institutional Review Board approval received.
- E-mails to physician practice sample began in late July 2023.
- E-mails to non-MD/DO practice, IDTFs and independent labs sample began in early 2024.
- Availability and reliability of e-mail addresses within the IQVIA's OneKey data was an issue. AMA and Mathematica conducted numerous lookups to improve information. Nearly 20% of the sample selected did not have accurate financial expert names or contact information. An additional 40+% had names but no email information.
- Mathematica also mailed the surveys to each practice.

Direct Patient Care Hour Surveys

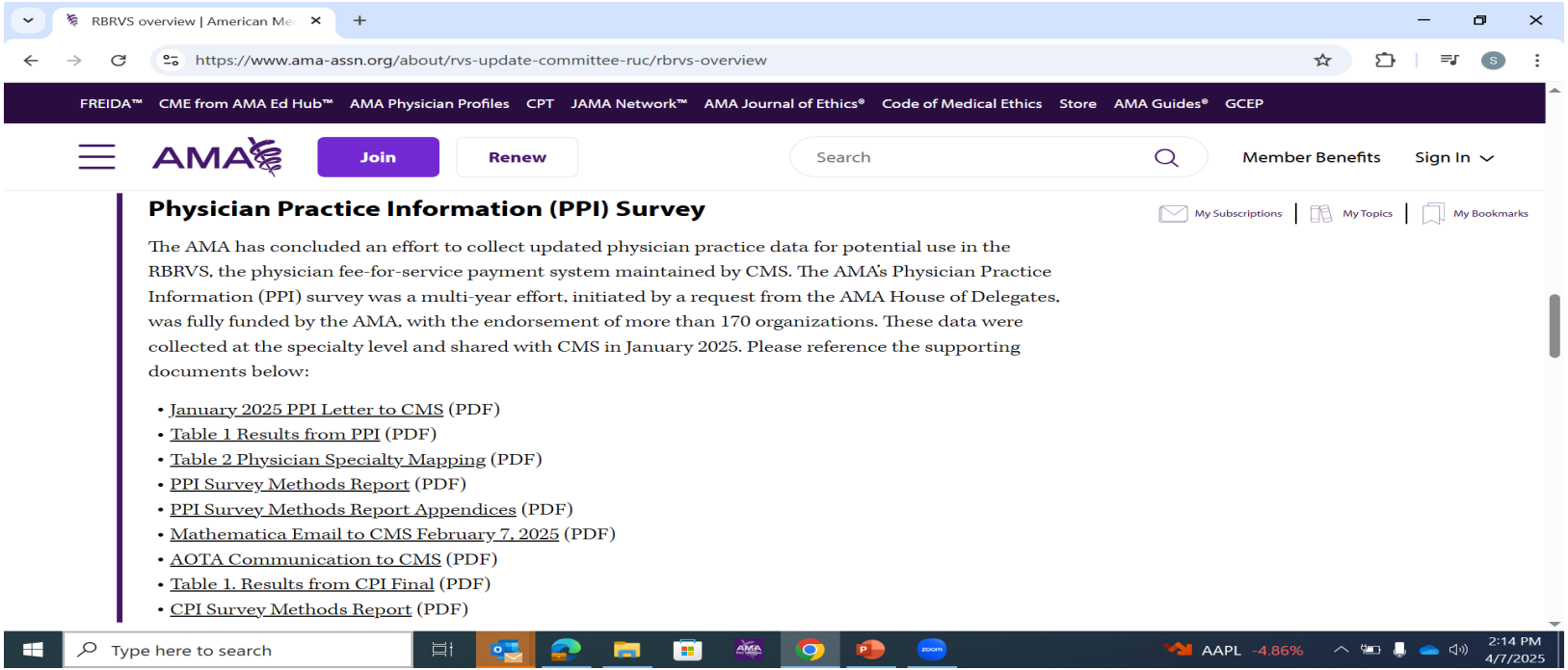
- Mathematica emailed physicians from the sampled practices to collect patient care hours and to inform those physicians that their practice was invited to participate in the PPI Survey effort.
- The AMA and Medscape also directly contacted physicians to collect direct patient care hours and encourage physician engagement to ensure practice surveys were completed.
- Reponses to the hours survey were received from 5,690 physicians.

PPI Survey Concluded September 2024

- The PPI Survey concluded with 380 practices providing usable data for 831 departments. These departments included 18,086 physicians. Some practices were also able to allocate costs to nurse practitioners and physician assistants. The response rate was 6.8%.
- The non-MD/DO survey concluded with 317 practices providing usable data and included 2,548 other health care professionals. The response rate was 9.1%.
- Practice expense and direct patient care hour data for physicians and other health care professionals were submitted to CMS in advance of the February 10, 2025, due date. The IDTF community has not yet submitted survey data to CMS as they are working to determine a direct patient care hours alternative.

PPI Survey Resources on AMA Website

- The PPI Survey Resources are in the Relative Update Committee (RUC) agenda materials, the RUC collaboration site, and publicly on the AMA Website.



Differences between 2007/2008 and 2023/2024 PPI Survey Efforts

- Previous PPI focused on the individual physician; New PPI focused on the practice (TIN).
- Previous PPI sample from the AMA Physician Professional Data; New PPI sample from MD-PPAS (OneKey for pediatric practices).
- Previous PPI was administered via phone, fax, mail, and online; New PPI administered *solely* online.
- Previous PPI point of contact was the physician; New PPI point of contact was the financial expert.

PPI Sampling

- Practices were defined as TINs and selected from the MD-PPAS data (OneKey for pediatric practices).
- TINs were sampled based on practice attributes thought to be correlated with practice expense.
  - Practice size
  - % of allowed charges in a facility setting
  - Whether single (39) or multi-specialty (6)
  - Practice ownership

Combining Specialty-level Data

- Practices were asked to provide expense data separately for each Medicare specialty (65) in their practice.
- Because of small sample size and because some practices combined specialties when reporting, we grouped expense data into 18 categories. Table 2 on the earlier linked website provides the full mapping.
- Combinations were based on similarities across specialties in 2006 expense data, similarities in site-of-service billing, and function.

Calculation of practice expense per hour (PE/HR)

Physician Hours Survey

- Grouped the hours data into 18 specialty categories.
- Defined a physician as full time (hours >= 35) or part time.
- Computed mean hours and mean weeks separately for full and part time physicians in each specialty category.

	Hours per week	Weeks per year	Hours per year
Part time	21	43	930
Full time	52	45	2316
All	44	44	1936

Calculation of PE/HR (continued)

Practice Survey

- Excluded departments that did not report any expense data or had number of physicians inconsistent with other data reported.
- Calculated annual total hours of patient care for each department. Multiplied the numbers of physicians in each department by mean hours and mean weeks, separately for full and part time physicians.
- Divided each expense variable by annual total hours of patient care.
- Trimmed outliers.
- Imputed missing values based on specialty means and, depending on expense category, subcategories within specialty (% of billing in the facility setting or size).

Weighting

- Due to sample size, the weighting methodology was based on only subset of variables (and categories) used in sampling, prioritizing those thought to have the greatest correlation with practice expense.

- Weights accounted for practice specialty; % of billing in the facility setting within each practice; specialties within each of the 18 groupings; and practice size.

Annual Hours, Direct, Indirect, and Total PE/HR: Physicians

Broad specialty	Mean annual hours of direct patient care	Mean direct PE/HR	Mean indirect PE/HR	Mean PE/HR
Cardiology	2265	77.55	132.00	209.55
Dermatology	1636	103.82	146.63	250.46
Gastroenterology	2025	54.31	117.02	171.34
Hematology/Oncology	1763	109.62	132.38	242.00
Hospital Based Medicine	1768	6.61	56.52	63.13
Hospital Based Surgery	2448	32.54	62.39	94.93
Obstetrics/Gynecology	2063	61.57	101.05	162.62
Office Based Medicine	1849	34.60	75.32	109.92
Office Based Proceduralist	2170	63.03	110.95	173.98

Annual Hours, Direct, Indirect, and Total PE/HR: Physicians (continued)

Broad specialty	Mean annual hours of direct patient care	Mean direct PE/HR	Mean indirect PE/HR	Mean PE/HR
Ophthalmology	1812	96.83	200.36	297.19
Orthopaedic Surgery	2397	41.65	113.50	155.15
Otolaryngology	2296	47.91	100.44	148.35
Pathology	2036	19.13	46.79	65.92
Primary Care	1851	48.55	97.14	145.70
Psychiatry	1407	9.25	28.84	38.10
Pulmonary Disease	2028	41.00	92.44	133.43
Radiology	1781	58.79	118.12	176.91
Vascular Surgery	2486	87.96	117.35	205.32
All	1936	42.56	91.04	133.61

Annual Hours, Direct, Indirect, and Total PE/HR: Health Care Professionals

Broad specialty	Mean annual hours of direct patient care	Mean direct PE/HR	Mean indirect PE/HR	Mean PE/HR
Audiology	1498	34.15	123.60	157.75
Chiropractic	1652	40.69	64.44	105.13
Clinical Laboratory	1723	109.45	103.50	212.94
Clinical Psychology/Psychology	1377	14.73	45.39	60.12
Licensed Clinical Social Worker	1385	25.04	23.85	48.89
Nurse Practitioner	1509	38.03	41.94	79.97

Annual Hours, Direct, Indirect, and Total PE/HR: Health Care Professionals (continued)

Broad specialty	Mean annual hours of direct patient care	Mean direct PE/HR	Mean indirect PE/HR	Mean PE/HR
Optometry	1548	125.05	118.69	243.74
Oral Surgery	1524	243.89	338.41	582.29
Physical Therapy	1648	29.48	59.21	88.69
Physician Assistant	1583	32.59	49.59	82.18
Podiatry	1592	43.70	89.95	133.65
Registered Dietitian	1036	21.87	41.55	63.42
Speech Language Pathology	982	9.71	26.93	36.64

Components of Direct and Indirect PE/HR (all physicians)

Clinical	Supplies	Equipment	Total direct
33.02	6.77	2.77	42.56

Administrative	Overhead	Information technology	Other	Total indirect
29.30	24.29	6.55	30.91	91.04

Medicare Economic Index (MEI)

	1975-1992	1993	1996	2000	Currently Used – 2006 Data	Updated CMS MEI Weights (Postponed)	**2024 PPI**
Physician Work	60.0%	54.2%	54.5%	52.5%	50.9%	47.5%*	60.8%
Practice Expense (PE)	40.0%	41.0%	42.4%	43.7%	44.8%	51.1%*	37.0%
Professional Liability Insurance (PLI)	(incl with PE)	4.8%	3.2%	3.9%	4.3%	1.3%	2.3%

*AMA Comment: New CMS MEI is flawed because it excludes hospital-based physicians.

What do Size and Site-of-Service Have to do With it?

- As practice size increases...
  - Direct and indirect PE contribute a *smaller* share of the total.
  - Fixed costs spread across more physicians.
  - Work contributes a *larger* share.
- As the share of billing in the facility setting increases…
  - Direct and indirect PE contribute a *smaller* share of the total.
  - The facility incurs some direct and indirect expenses.
  - Work contributes a *larger* share.

Practice Size Variation in Practice Expense & MEI

Practice size	Total direct	Total indirect	Total PE	Provider work	PLI	MEI Expense
Practice expense per hour						
1 to 10	48.67	93.42	142.09	140.00	6.00	288.09
11 to 100	43.30	98.11	141.41	232.30	4.89	378.61
101+	34.11	76.50	110.61	202.69	8.58	321.87
Missing	76.23	163.43	239.67	234.42	4.75	478.84
All	42.56	91.04	133.61	194.32	6.95	334.87
MEI						
1 to 10	15.8%	31.8%	47.6%	50.1%	2.3%	100%
11 to 100	8.4%	23.7%	32.1%	66.5%	1.4%	100%
101+	9.5%	22.5%	32.1%	65.2%	2.8%	100%
Missing	14.8%	30.6%	45.5%	53.3%	1.2%	100%
All	11.3%	25.7%	37.0%	60.8%	2.3%	100%

Department Billing Variation in Practice Expense & MEI

% of billing in facility	Total direct	Total indirect	Total PE	Provider work	PLI	MEI Expense
			Practice expense per hour			
less than 25%	59.19	108.06	167.25	176.52	7.90	351.66
25% to LT 50%	61.07	116.89	177.96	220.65	9.46	408.08
50% to LT 75%	56.04	99.71	155.75	211.01	5.65	372.40
75% +	29.94	83.04	112.98	195.85	6.71	315.54
Missing	50.52	85.99	136.51	193.45	6.32	336.29
All	42.56	91.04	133.61	194.32	6.95	334.87
			MEI			
less than 25%	15.3%	29.7%	45.0%	52.7%	2.4%	100%
25% to LT 50%	14.7%	27.8%	42.6%	54.8%	2.6%	100%
50% to LT 75%	13.1%	26.4%	39.5%	59.8%	1.7%	100%
75% +	8.4%	24.8%	33.2%	64.5%	2.3%	100%
Missing	13.7%	23.5%	37.2%	60.5%	2.3%	100%
All	11.3%	25.7%	37.0%	60.8%	2.3%	100%

Practice Billing Variation in Practice Expense & MEI

% of billing in facility	Total direct	Total indirect	Total PE	Provider work	PLI	MEI Expense
			Practice expense per hour			
less than 25%	62.57	106.55	169.12	159.08	6.46	334.66
25% to LT 50%	68.17	135.00	203.17	221.20	6.01	430.38
50% to LT 75%	40.01	91.66	131.68	218.01	10.05	359.74
75% +	19.01	56.43	75.44	188.28	6.60	270.32
Missing	70.24	139.30	209.54	199.47	4.58	413.60
All	42.56	91.04	133.61	194.32	6.95	334.87
			MEI			
less than 25%	16.8%	31.4%	48.2%	49.5%	2.4%	100%
25% to LT 50%	13.9%	30.1%	44.1%	54.3%	1.7%	100%
50% to LT 75%	10.7%	24.9%	35.6%	61.9%	2.6%	100%
75% +	6.8%	20.8%	27.6%	69.9%	2.5%	100%
Missing	16.8%	30.7%	47.5%	51.1%	1.4%	100%
All	11.3%	25.7%	37.0%	60.8%	2.3%	100%

Regressions That Control for Specialty Show…

- On average, in practices with 50 or more physicians compared to practices with 10 or fewer physicians:
  - Overhead per hour is $19 lower
  - Direct shares are 11 percentage points lower
  - Indirect shares are 12 percentage points lower
- On average, a 1 percentage point increase in facility billing for a department is associated with a:
  - $0.33 decrease in direct PE/HR
  - $0.48 decrease in indirect PE/HR

Concluding thoughts

- Participation still hard to obtain but for different reasons.
- Physicians are no longer the appropriate point of contact. 44% of physicians were owners in 2022 compared to 61% in 2007.
- Practices (TINs) are a better point of contact but contact information is lacking.
- Even when contact information is accurate, security measures (SPAM filters) affect response.
- Some practices track expenses across TINs or within TINs.
- Some practices don’t track expenses at the detailed specialty level currently used by CMS.
- Attention must be paid to sampling and weighting. While physician characteristics were key in 2007 (e.g., age and gender) practice characteristics (e.g., size and site-of-service) are now more important.

Physicians' powerful ally in patient care