

**AMA/Specialty Society RVS Update Committee
The Westin Chicago River North, Chicago, IL
April 23-25, 2026**

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in April 2026. Doctor Ezequiel Silva III called the meeting to order on Friday, April 15, 2026, at 10:00 a.m. CT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:

Ezequiel Silva III, MD
Amr Abouleish, MD
Margie C. Andreae, MD
Amy Aronsky, DO
Gregory L. Barkley, MD
Luke Barré, MD
Elizabeth Blanchard, MD
James Blankenship, MD
R. Dale Blasier, MD
Audrey Chun, MD
Joseph Cleveland, MD
Gregory DeMeo, DO
Leisha Eiten, AuD
Alexandra Flamm, MD
Martha Gray, MD
Matthew J. Grierson, MD
Gregory Harris, MD
Peter Hollmann, MD
Scott Manaker, MD
Bradley Marple, MD
John McAllister, MD
Swati Mehrotra, MD
Anne Miller, MD
Gregory Nicola, MD
Michael Perskin, MD
John Proctor, MD
Kyle Richards, MD
Donald J. Selzer, MD
G. Edward Vates, MD
Mark T. Villa, MD
Thomas J. Weida, MD

RUC Alternates:

Jennifer Aloff, MD
Anita Arnold, DO
Eileen Brewer, MD
Neal Cohen, MD
Patrick Godbey, MD
David C. Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
Bryan Johnson, MD
Kevin Kerber, MD
Kristopher Kimmell, MD
Timothy Laing, MD
Arturo Loaiza-Bonilla, MD
Mollie MacCormack, MD
Lance Manning, MD
Lauren Nicola, MD
Linda Parsi, MD
Lisa Price, MD
Noah Raizman, MD
Sanjay Samy, MD
Christopher Shale, MD
James Shoemaker, MD
Clarice Sinn, DO
Michael Sutherland, MD
Timothy Swan, MD
Thomas Turk, MD
David Vollman, MD
Mary Walsh-Sterup, OTR/L
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 relayed 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 CPT Editorial Panel representative:
 - Timothy Swan, MD – CPT Panel Member
- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) attendees:
 - Mitali Dayal, MSPH – Acting Deputy Director, Hospital and Ambulatory Policy Group
 - Stefanie Fischell, MD – Medical Officer
 - Edith Hambrick, MD – Medical Officer
- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) virtual attendees:
 - Perry Alexion, MD
 - Lindsey Baldwin, MA

- Morgan Kitzmiller, MHA
 - Sarah Leipnik
 - Ann Marshall, MSPH
 - Mikayla Murphy, MPH
 - Maya Peterson, MSN, RN
- Doctor Silva welcomed the following Contractor Medical Director:
 - Janet Lawrence, MD
- Doctor Silva welcomed those from the Medicare Payment Advisory Commission (MedPAC) attending both in-person and virtually:
 - Brian O'Donnell, MPP
 - Rachel Burton, MPP (*virtual*)
 - Geoff Gerhardt, MPP (*virtual*)
- Doctor Silva welcomed those from the U.S. Government Accountability Office (GAO) attending virtually:
 - Greg Giusto, MPH – Assistant Director, Health Care Issue
 - Pamela (Mela) Brown, MSc – Senior Analyst
 - Caylin Rathburn-Smith, MSW, MPH – Senior Analyst
- Doctor Silva recognized new RUC members:
 - Elizabeth Blanchard, MD – American Society of Clinical Oncology (ASCO)
 - Martha Gray, MD – American College of Physicians (ACP)
 - Michael H. Perskin, MD – Primary Care Rotating Seat (PCRS)
- Doctor Silva recognized new RUC Alternates:
 - Jennifer Aloff, MD – American Academy of Family Physicians (AAFP)
 - Bryan Johnson, MD – American College of Physicians (ACP)
 - Arturo Loaiza-Bonilla, MD – American Society of Clinical Oncology (ASCO)
 - Linda Parsi, MD – Primary Care Rotating Seat (PCRS)
 - Lisa Price, MD – American Geriatrics Society (AGS)
 - Mary Walsh-Sterup, OTR/L – Health Care Professionals Advisory Committee (HCPAC)
- 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 relayed the following procedural guideline relating to New Business:
 - Throughout this meeting, if you have potential items for new business, please let AMA staff and/or the RUC Chair know so we may guide you to existing resources, if applicable.
- 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.
- Doctor Silva acknowledged the RUC's 35th anniversary!

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 reviewed the RUC Database – 2026 v 2.1:
 - 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.
 - 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 2024 Medicare claims data and 2026 Non-Alternative Payment Model (APM) Conversion Factor (CF).
 - New version includes CMS Adjusted Intra-Service Time and Adjusted Total Time on the Physician Time tab.
- 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 2028 and 2029 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Aug 25, 2026	Sep 24-26, 2026	Chicago, IL	CPT 2028
Dec 15, 2026	Jan 20-23, 2027	Del Mar, CA	CPT 2028
Apr 6, 2027	Apr 29-May 1, 2027	Chicago, IL	CPT 2029

- Ms. Smith stated that the RUC now offers Continuing Medical Education (CME) credits for RUC Meeting Participation:
 - Physicians can earn up to 19.00 AMA *PRA Category 1 Credits*TM 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 1, 2026.
 - Once you have successfully completed the evaluation, a certificate will be automatically available on May 15, 2026, in the “Transcript” section of your [AMA Ed Hub](#) account.
- Ms. Smith announced a change to the publication of the RUC Recommendations:
 - RUC recommendations are now published on the [AMA site](#) immediately after submission to CMS.
- Ms. Smith discussed access to RUC agenda files:

- The agenda materials are posted as individual tabs for ease and real-time updates.
- There are additional folders for revised materials prior to the meeting and at the meeting. However, these files are incorporated in the specific agenda tabs as well.
- A zipped folder of the entire agenda materials was updated this morning.
- Ms. Smith addressed the RUC Chair & AMA Representative seats:
 - RUC Chair – 3 two-year terms
 - AMA Representative and Alternate Representative – 2 three-year terms
 - Request for Nominations will be distributed from AMA leadership in mid-Summer
 - Board election will occur in November
 - Terms will start March 1, 2027

IV. Approval of Minutes from the January 2026 RUC Meeting

The RUC approved the January 2026 RUC meeting minutes, with the addition of one staff note:

- A RUC member noted the proposed changes to the medical decision making (MDM) table for discussion at the February 2026 CPT Editorial Panel meeting. The RUC member asked if these issues would be referred to the former joint CPT and RUC E/M workgroup. A RUC member asked for clarification regarding the timing of when the workgroup was disbanded. Therefore, the minutes revised to include the following staff note: The CPT Editorial Panel has disbanded this workgroup, and all discussion on the coding proposal will be considered by the full CPT Editorial Panel.

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:

- Upcoming CPT Panel Meeting Activity – May 2026
 - RUC Referrals to be reviewed at the May 2026 Panel Meeting:
 - Bronchoscopy with Robotic Assistance-Revise 31627 (Tab 10)
 - Peri-prostatic Implantation Biodegradable Material (Tab 11)
 - Intraoperative Monitoring (Tab 32) – withdrawn
 - Interventional Transesophageal Echocardiography (Tab 33)
- May 2026 Panel Meeting
 - 65 Code Change Applications (CCAs) Submitted
 - Notable Agenda Items
 - 13 Digital medicine related CCAs
 - 32 Category III code applications
 - 2 codes for CPT Code Set Maintenance
- May 2026 CPT Panel Meeting CCAs
 - Prescription Management Risk Guidelines (Tab 4): Postponed from February 2026. Editorially revise the Evaluation Management (E/M) Risk of Complications and/or Morbidity or Mortality of Patient Management guidelines with the addition of a definition for prescription drug management risk. No code changes are included in this request.

- Enzymatic Injection-Plantar Fascia (Tab 5): Establish Category I code 2XXX0 for reporting plantar fascia nodule for treatment of ledderhose disease and plantar fibromatosis with enzymatic injections.
- Injection Bone Substitute-Subchondral Defect (Tab 6): Establish Category I code 2XXX1 to report injections of bone-substitute material into subchondral defect of bone in the knee using imaging guidance, and revise Category III code 0707T to report injections of bone-substitute material into subchondral defect of bone, other than knee.
- Slipped Rib Syndrome Surgery (Tab 7): Establish Category I code 21XXX to report open treatment of a slipped rib.
- Extra-osseous Stabilization-Talotarsal Joint (Tab 8): Establish Category I code 28XX0 to report extra-osseous stabilization of talotarsal joint.
- Tibial Nerve Neurostimulation (Tab 9): (1) Establish four Category I codes 64X25, 64X26, 64X27, 64X28 and corresponding parenthetical notes to report tibial nerve integrated neurostimulation system; (2) delete Category III codes 0816T, 0817T, 0818T, 0819T; (3) revise Category III code 0988T to create a parent code describing open insertion or replacement of integrated neurostimulation system; (4) revise Category III code 0989T to create a parent code describing revision or removal of integrated neurostimulation system; (5) revise parenthetical notes following 0988T, 0989T; and (64) add, revise and delete parenthetical notes throughout the code set.
- Open Posterior Tibial Neurostimulator Services (Tab 68): (1) Establish four new Category I codes 64X21, 64X22, 64X23, 64X24 and corresponding parenthetical notes to report open posterior tibial neurostimulator services; (2) revise guidelines in the Neurostimulators (Peripheral Nerve) subsection of the code set; (3) delete Category III codes 0816T, 0817T, 0818T, 0819T and corresponding parenthetical notes; and (4) add, delete and revise several parenthetical notes throughout the code set.
- Bronchoscopy with Robotic Assistance-Revise 31627 (Tab 10*): Revise Category I add-on code 31627 to include robotic assistance as part of the procedure.
- Peri-prostatic Implantation Biodegradable Material (Tab 11*): Establish code 55XX0 to report transperineal placement of biodegradable material with placement of interstitial devices for radiation therapy.
- Implantation Cranial Nerve Neurostim-Revise 64568-64570 (Tab 12): Revise Category I codes 64568, 64569, 64570 to exclude hypoglossal nerve and add parentheticals under each code to refer to the appropriate hypoglossal nerve codes (64582, 64583, 64584).
- Open Implantation Cranial Nerve Neurostim-Hypoglossal Nerve (Tab 13): Establish a Category I code 64XXX to the Neurostimulators (Peripheral Nerve) subsection in addition to new parentheticals, revise code 64568, and add new parentheticals to refer to the new code for the implantation of a single lead hypoglossal nerve neurostimulator electrode array and pulse generator.
- PET CT-Metabolic Abnormalities (Tab 14): Establish Category I add-on code 78XXX to report standardized, corrected, quantitative analysis of individual metabolic abnormalities for positron emission tomography.
- Speech Language Treatment Services-92507 (Tab 29)
 - 2024: The Relativity Assessment Workgroup (RAW) identified significant growth in Medicare utilization for CPT code 92507, prompting a recommendation to modernize and clarify its descriptions and coding granularity to better reflect current speech-language pathology practice patterns and evolving treatment services, which have not been reviewed since 2010.
 - Sept. 2025: CPT Panel accepted deletion of code 92507 and revision of code 92508. The Special Otorhinolaryngologic Services subsection guidelines were revised and ten new codes 92X0X-92X9X were added to account for the work

- previously reported using 92507 for the treatment of speech, language, voice, communication, and auditory processing disorders.
 - Jan. 2026: The RUC recommended values for these new codes at the January 2026 meeting.
 - Feb. 2026: Tab 29 submitted and requests to reinstate code 92507 and delete the CPT codes 92X0X–92X9X. *This new CCA was submitted by Fix SLP, LLC, Adler Therapy / Group, American Academy of Private Practice in Speech Pathology and Audiology (AAPPSPA), MetroEHS Pediatric Therapy.*
 - AI Coronary FFR-Angiogram Data (Tab 31): Delete intraprocedural coronary fractional flow reserve (FFR) Category III add-on code 0523T and establish Category I add-on code 93XXX for reporting intraprocedural coronary FFR, with augmentative artificial intelligence and 3D functional mapping of FFR values for the coronary tree, derived from coronary angiogram data for real-time review and interpretation.
 - Intraoperative Monitoring (Tab 32*): Establish Category I codes 95X10, 95X11 and corresponding parenthetical notes reporting intraoperative neurophysiologic monitoring, revise Category I codes 95940, 95941 and corresponding parenthetical notes, and revise the guidelines in the intraoperative neurophysiology subsection. Withdrawn Tab
 - Interventional Transesophageal Echocardiography (Tab 33*): Establish Category I codes 93XX7-93X10 with corresponding guidelines and parenthetical notes to differentiate standard and high complexity transesophageal interventional echocardiography procedures, delete code 93355.
- CPT Ad Hoc Workgroups: Update - Digital Medicine Coding Committee (DMCC)
 - Co-Chairs: Richard Frank, MD, PhD, Mark Synovec, MD
 - Tab 67-Appendix S Revisions will be discussed at the May CPT Editorial Panel meeting. This tab will be a continuation of the proposal that was postponed time certain at the February Panel meeting and incorporates suggestions from the Panel and other stakeholders.
 - Revisions with interested parties and CPT Advisors ahead of the May 2026 CPT Editorial Panel Meeting. Due to interest in this tab, this session served as an opportunity for stakeholders to comment prior to the Panel meeting.
 - CPT Ad Hoc Workgroups: Update - Value Based Care (VBC) Services Workgroup
 - Co-Chairs: Barbara Levy, MD and Sameer Berry, MD
 - An open stakeholder hybrid meeting took place at the February 2026 CPT Editorial Panel Meeting.
 - The gastrointestinal (GI) subgroup and the musculoskeletal (MSK) subgroup have been working on use cases to inform the overall trajectory of the workgroup.
 - Both subgroups are looking at the bundle model and the multi-level model based on the identified conditions/diagnoses. For GI they are looking at lower-GI symptoms and irritable bowel disease. For MSK the condition is lower back pain.
 - The workgroup met on March 30 to review the bundling approach.
 - CPT Ad Hoc Workgroups: Update - Neurostimulator Workgroup (New)
 - Co-Chairs: Timothy Swan, MD and Jonathan Rubenstein, MD
 - A workgroup was requested by the CPT Editorial Panel Chair to handle a variety of issues related to neurostimulators. Workgroup charge:
 - Evaluate and clarify the CPT coding structure for neurostimulator systems by addressing stakeholder concerns and potential gaps in current

guidance to achieve consistent application of the definitions across services currently provided by physicians. The group will assess whether new codes or revisions are needed to address confusion around physician work related to integrated and non-integrated systems.

- The first meeting was held on March 23 with all members in attendance.
 - The meeting was introductory to the workgroup and workgroup expectations as some are not familiar.
 - Part of the agenda was to level-set what CPT is and how CPT is used to define services.
 - Homework was assigned to begin to look at neurostimulator terminology and how to define it in the context of CPT and physician work.
 - The next workgroup meeting will be held in mid-May.
- May 2026 Panel Meeting
 - The next Panel meeting is April 30 – May 2, 2026, in Boston, MA.
 - The next application submission deadline for the following cycle is June 10, 2026.

VI. Centers for Medicare & Medicaid Services Update

Mitali Dayal, MSPH, Acting Deputy Director, Hospital and Ambulatory Policy Group provided the report of the Centers for Medicare & Medicaid Services (CMS).

- Ms. Dayal noted that she is joined by two medical officers, Doctors Edith Hambrick and Stefanie Fischell, with others observing online.
- Ms. Dayal noted that it is her first time at the RUC, so she would like to introduce herself.
 - Ms. Dayal has been with CMS for nearly 10 years
 - Ms. Dayal started in the CMS innovation center focusing on primary care payment models and later moved to the division of outpatient care where she works on the Outpatient Prospective Payment System (OPPS).
 - Ms. Dayal's current position is the Acting Deputy Director of the Hospital and Ambulatory Policy Group, her permanent role is as the deputy director of the outpatient division, working on the OPPS. She is currently detailing at the group level, which has allowed her to learn and engage more deeply with the physician fee schedule work.
- Ms. Dayal acknowledged Heather Grimsley as the current Acting Deputy Director of the Center for Medicare on the traditional Medicare side.
- Ms. Dayal explained that they are in the midst of developing the annual physician fee schedule (PFS) and OPPS proposed rules, which always make this time very exciting and busy.
- Ms. Dayal noted that throughout this process, they remained focused on improving the quality of care for Medicare beneficiaries while significantly reducing unnecessary spending and promoting payment accuracy.
- Ms. Dayal expressed understanding of how the RUC makes key contributions to the process, and she is looking forward to the opportunity to observe that process today.

VII. Contractor Medical Director Update

Janet Lawrence, MD, MS, FACP, Contractor Medical Director (CMD), First Coast Service Options, Inc. (FCSO), provided the CMD update.

- Medicare Enrollment Snapshot
 - Enrollment Distribution
 - 54% of beneficiaries are enrolled in Medicare Advantage plans, while 46% remain in Traditional Medicare.
 - Growth of Medicare Advantage Plans
 - The number of Medicare Advantage and Prescription Drug plans continues to grow, ranging from 3,700 to over 5,200 nationally.
 - Implications for Providers
 - Increasing enrollment in Medicare Advantage affects providers due to plan-specific rules, networks, and utilization requirements.
 - Medical Director Perspective
 - Understanding enrollment is vital for interpreting coverage, audits, and directing issues to the appropriate Medicare Advantage plans.
- Traditional Medicare Overview
 - Medicare Administration
 - Traditional Medicare is managed by CMS, allowing beneficiaries to access any approved provider nationwide, freely.
 - Coverage Components
 - Part A covers inpatient hospital services, and Part B includes physician, outpatient, and preventive care services.
 - Payment and Claims Processing
 - Payments are based on fee schedules and prospective systems, with claims managed by Medicare Administrative Contractors.
 - Oversight and Coverage Policies
 - National and local coverage determinations guide service reimbursements, supported by review programs for billing accuracy.
- Medicare Advantage (Part C) Overview
 - Medicare Advantage Plan Structure
 - Medicare Advantage plans are offered by private insurers and operate through specific provider networks like HMOs and PPOs.
 - Comprehensive Coverage
 - These plans cover all Part A and B services and often include prescription drugs and supplemental benefits like dental and vision.
 - Claims and Coverage Management
 - Coverage disputes and claims under Medicare Advantage are handled by the plan, not traditional Medicare administrators.
 - Regulatory Differences
 - Medicare Advantage plans have unique regulatory frameworks and appeal processes distinct from Traditional Medicare

- Supplemental Medical Review Contractor (SMRC)
 - SMRC Role and Purpose
 - SMRC conducts nationwide medical reviews to ensure Medicare payment accuracy and integrity.
 - Scope of Review
 - Reviews include Medicare Part A, Part B, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), and sometimes Medicaid claims under CMS direction.
 - Core Functions
 - SMRC requests records, evaluates coding accuracy, identifies improper payments, and reports findings.
 - National Oversight Role
 - Serves as a national oversight mechanism identifying systemic issues to support CMS policies.
- Comprehensive Error Rate Testing (CERT) Overview
 - Purpose of CERT Program
 - CERT measures improper payment rates in Medicare Fee-For-Service through statistical claim reviews.
 - Not a Fraud Detection Program
 - CERT focuses on payment accuracy and does not assign fault or detect fraud, ensuring objective findings.
 - Medicare Advantage Exclusion
 - Medicare Advantage claims are handled separately outside the CERT program by respective plans or CMS.
 - Use of CERT Findings
 - CERT data supports program integrity and informs corrective actions and education without blame.
- CERT Contractors and Roles
 - Statistical Contractor Role
 - Designs sampling methods and selects random Medicare claims samples for improper payment rate calculation.
 - Review Contractor Role
 - Requests medical records, reviews claim documentation, and determines payment accuracy for sampled claims.
 - Quality Control and Reporting
 - Maintains provider status websites, performs quality control of medical record imaging, and ensures reliable CERT findings.
 - Role Importance for Medical Directors
 - Understanding contractor roles helps Medical Directors accurately interpret CERT data and differentiate measurement from enforcement.
- Recovery Audit Contractors (RAC)
 - Role of RACs
 - RACs identify and correct improper Medicare Fee-For-Service payments by auditing claims post-payment.
 - Focus on Payment Accuracy
 - RACs focus on payment accuracy and compliance, not fraud investigation.
 - Impact on Providers

- RAC activities affect provider behavior and policy interpretation within Medicare oversight.
- Objectives of RACs
 - Their mission includes detecting improper payments, recovering funds, preventing future errors, and supporting compliance.
- Unified Program Integrity Contractors (UPIC)
 - UPIC Role and Purpose
 - UPICs detect, prevent, and investigate fraud, waste, and abuse across Medicare and Medicaid programs.
 - Operational Functions
 - UPICs conduct investigations, medical reviews, documentation audits, and apply advanced data analytics to detect issues.
 - Collaboration and Enforcement
 - UPICs coordinate with CMS, state agencies, and law enforcement to protect federal healthcare funds and enforce regulations.
 - Organizational Structure
 - UPICs operate regionally, replacing Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs), and represent Medicare's most enforcement-focused program integrity component.
- Wasteful and Inappropriate Service Reduction (WiSeR)
 - Purpose and Scope
 - WiSeR aims to reduce wasteful and clinically unsupported services in Traditional Medicare over six years starting 2026.
 - Technological Approach
 - The model uses AI and machine learning for prior authorization and prepayment medical review to prevent fraud and waste early.
 - Geographic Implementation
 - WiSeR is initially implemented in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.
 - Impact on Medical Directors
 - Introduces new utilization management and clinical review challenges within Traditional Medicare for Medical Directors.
- Comparison of WiSeR, RAC, CERT, SMRC, and UPIC
 - WiSeR Program Focus
 - WiSeR uses AI for prior authorization and pre-payment review to reduce low-value services in Traditional Medicare.
 - RAC Post-Payment Audits
 - RAC identifies and corrects improper payments through post-payment audits of Medicare claims.
 - CERT Payment Accuracy Measurement
 - CERT uses statistical sampling to measure improper payment rates and evaluate payment accuracy without fraud investigation.
 - SMRC Nationwide Medical Reviews
 - SMRC performs nationwide medical reviews supporting payment accuracy and program integrity across services.
 - UPIC Fraud Investigations

- UPIC investigates fraud, waste, and abuse using data analytics, medical review, and law enforcement referrals.
- Recent Local Coverage Determination Updates
 - Botulinum Toxin and Radiation Therapy
 - Botulinum toxin injections and superficial radiation therapy for skin cancers are recognized as effective treatments with ongoing policy refinements.
 - Cardiac Monitoring Devices
 - Temporary nontherapeutic ambulatory cardiac monitoring devices are nearing final coverage decisions for key Medicare Administrative Contractors.
 - Peripheral Nerve Blocks and Allergy Diagnostics
 - Peripheral nerve block procedures progress in most MAC regions; allergy diagnostics comment period has recently closed.
 - Upcoming Advisory Meetings
 - Contractor Advisory Committee meetings planned for GERDx, LINX, and TearCare to discuss future coverage updates.
- Doctor Lawrence addressed the following questions:
 - A member asked a clarifying question if the referenced anti-fraud and abuse organizations have changed their approach or expanded their focus in response to recent discussion related to fraud and abuse. Doctor Lawrence responded that the process has not necessarily changed, however, there are more initiatives or projects to evaluate data, so the processes remain the same and all potential misuse is properly investigated.
 - A member stated that, from a physician perspective, there are multiple payers to manage, and when an additional payer plan is added, it raises the administrative costs to provide a service. In a big picture as health care costs rise, administrative costs that continue to grow cannot be ignored, and the opportunity to substantially decrease those costs if coverage options are limited.
 - The member also inquired about the different Medicare contractors and how miscoding should be adjudicated once it is identified through various RUC processes. Doctor Lawrence stated that if it is for traditional Medicare then depending on what jurisdiction you are in, it would be raised to the appropriate MAC. It was clarified that when miscoding is identified via the RUC/RAW process, CMS is notified. MACs are very receptive to medical specialty societies bringing miscoding forward since the expertise of the specialty carries significant weight.

VIII. Washington Update

Suzanne Joy, MPP, Director of Federal Affairs, AMA, and Bryan Hull, JD, Washington Counsel Legislative Affairs, AMA, provided the Washington report focusing on regulatory, legislative, and AMA advocacy updates. Please see full presentation attached for more details.

Regulatory Updates

- CY 2027 Medicare Advantage (MA) & Part D Final Rule / Rate Announcement Highlights
 - Finalized April 2 (CMS [fact sheet](#); [press release](#))
 - Higher-than-expected payment increase (0.09% in proposed notice versus 2.48% in final rate announcement)

- Will not count diagnosis obtained from chart reviews in MA risk scores unless there is a service provided to the patient for that diagnosis, which the AMA strongly supported. Will consider further changes to MA adjustment in future rulemaking.
- Several Requests for Information (RFIs) in proposed rule... stay tuned!
- See the AMA's [comment letter](#) >>
- FY 2027 Inpatient Prospective Payment System (IPPS) Proposed Rule
 - Released 4/10; Comments due 6/9
 - CMS [fact sheet](#); press release
 - Proposed increase in IPPS payment rates of 2.4%
 - Would expand the mandatory Comprehensive Care for Joint Replacement (CJR) Model nationally
 - Changes to various hospital quality reporting program measures
 - Medicare Promoting Interoperability changes
- Interoperability Standards & Prior Auth for Drugs Proposed Rule
 - Released April 10 (CMS [fact sheet](#); [press release](#))
 - Drugs moved to prior auth interoperability framework (AMA ask!!!)
 - Drug prior auth denials must have specific reason
 - Faster drug prior auth timelines (72 hours standard; 24 hours expedited)
 - New public prior auth & Application Programming Interface (API) usage metrics
 - Comments due June 15
 - Note: 2024 CMS Interoperability and Prior Authorization [Final Rule](#) also took effect 1/1/26
- New Center for Medicare and Medicaid Innovation (CMMI) APM Status Updates
 - Wasteful and Inappropriate Service Reduction (WiSeR) – inclusion of 2 services [delayed](#) until further notice after pushback
 - Ambulatory Specialty Model (ASM) – participant list [now available](#)
 - Advancing Chronic Care with Effective Scalable Solutions (ACCESS) - 150 applicants [accepted](#); application deadline extended to 5/15
 - Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (ELEVATE) – [applications](#) due 5/15 (must have previously submitted LOI)
 - Long-term Enhanced ACO Design (LEAD) – Request for applications ([RFA](#)) now available; applications due 5/17
 - Financial methodology details expected in summer
 - Accountable Care Organizations (ACOs) have until 8/5 to add participating Tax Identification Number (TINs) and preferred providers and until 9/8 to drop them

Legislative Updates

- Where Things Stand: Medicare Physician Payment in 2026
 - Temporary Updates (Expires Dec. 31, 2026):
 - +2.5% boost to 2026 CF
 - APM bonus & lower qualified professional (QP) threshold
 - Permanent Updates:
 - APM participants: +0.75% update

- All other physicians: +0.25% update
- AMA Medicare Payment Reform Legislative Priorities
 - Automatic Medicare Economic Index (MEI) Inflation-Based Updates
 - Budget Neutrality Reform
 - Merit-based Incentive Payment System (MIPS) Simplification
 - Expanded APM Opportunities
- Provider Reimbursement Stability Act (H.R. 8163)
 - Introduced in House March 31st
 - Raises budget neutrality trigger & requires cumulative MEI-based increase every 5 years
 - Requires Health and Human Services (HHS) to prospectively revise CF budget neutrality changes triggered by code utilization estimates based on actual claims data*
 - Requires CMS to update direct cost inputs for practice expense RVUs all at once and at least every 5 years
 - Caps conversion factor adjustments at +/- 2.5% each year
 - only for newly unbundled codes that exceed 0.1% of total PFS spending
 - Next steps:
 - AMA federation letter of support
 - Secure additional cosponsors in the House
 - House markup (potentially in Ways and Means first)
 - Senate companion bill
- Strengthening Medicare for Patients and Providers Act (H.R. 6160)
 - Introduced 11/19/25
 - Single conversion factor tied to annual % change in MEI
 - In December, the AMA sent a [letter of support](#)
 - Cost remains the largest barrier to passage (\$350B over 10 years)
 - Momentum for the concept of an MEI-based update is building...
- Medicare Access and CHIP Reauthorization Act (MACRA) Reform - Doc Caucus Proposal
 - Came after years of AMA advocacy
 - Biproduct of RFI from House GOP and House Dem Doctors' Caucuses
 - Main sections are:
 - Ties CF updates to MEI (MEI – 1 plus floors and ceilings)
 - Targeted MIPS reform
 - APM/CMMI reform
 - Budget neutrality reform (mirrors H.R. 8163)
 - Next steps:
 - Draft legislative language
 - Build consensus support across House of Medicine
 - Still need bipartisan support from many parts of House leadership & bicameral committees' of jurisdiction. Still a long road ahead!
- Improving Seniors' Timely Access to Care Act (H.R. 3514/S. 1816)
 - Requires electronic prior auth
 - Includes transparency provisions
 - Authorizes CMS to implement tighter deadlines (e.g. 24 hours for urgent care)
 - Requires prior authorization (PA) requirements to be based on evidence & reviewed annually

- [AMA Testimony of support before E&C Health Subcommittee](#) (March 2026)
- H-1Bs for Physicians & Healthcare Workforce Act (H.R. 7961)
 - Exempts physicians/other health professionals from \$100k H-1B fee on a prospective basis
 - [April 15 sign-on letter](#)
 - [April 13 AMA letter](#)
 - Generating press & putting pressure on administration (largely the goal)
 - Senate companion bill in the works
- Congressional Hearings
 - On March 18, Chair of the AMA Board of Trustees, David Aizuss, [testified](#) before the U.S. House Energy and Commerce Committee's Subcommittee on Health
 - Hearing on lowering costs focusing on the provider landscape.
 - There have also been multiple hearings on healthcare pricing with insurers testifying.
- Unofficial Congressional Calendar (See presentation)

Speed Round: By Topic

- AI Augmented (Not Artificial!) Intelligence
 - AMA [launches](#) new Center for Digital Health and AI (Oct. 2025)
 - AMA [AI principles](#) (Nov. 2024)
 - Ongoing correspondence with federal policy makers
 - In letters to the [Congressional Artificial Intelligence Caucus](#) (PDF), the [Congressional Digital Health Caucus](#) (PDF), and the [Senate Artificial Intelligence Caucus](#) (PDF), the AMA urged federal lawmakers to put stronger safeguards in place as the use of AI chatbots in mental health care continues to grow (April 2026)
 - AMA response to the Health and Human Services (HHS) Request for Information (RFI) on accelerating adoption of AI as part of clinical care (Feb. 2026)
 - [AMA response](#) to Congressional inquiry on state of AI in healthcare (May 2024)
 - AMA [testimony](#) to Senate Finance on AI in healthcare (Feb. 2024)
 - Working with state medical societies on emerging issues such as chatbot regulation, transparency requirements, etc.
 - New issues always emerging (e.g. deep fake technology; autonomous practice of medicine/AI agents; counteracting bias, data privacy and security concerns, etc...)
- Vaccines/Advisory Committee on Immunization Practices (ACIP)
 - On April 15, 2026, the AMA was among 130 organizations that joined the American Academy of Pediatrics in issuing a [media statement](#) expressing deep concern about the newly revised charter for ACIP.
 - “The new charter substantively changes the focus of the committee and its membership structure, which could undermine confidence in vaccines and ultimately affect access to immunizations.”
 - “ACIP’s recommendations are tied to 13 federal statutes and define vaccine coverage for Medicare, Medicaid, Tricare, the Veteran’s Health Administration, and the Vaccines for Children program.”

- “As medical, public health and patient advocacy organizations, we call for an ACIP charter that correctly and comprehensively evaluates scientific data.”
- Medicaid
 - Ready for Medicaid work requirements by Jan. 1, 2027
 - Guidance due out by June 1st – interim final rule currently pending at the Office of Management and Budget (OMB)
 - AMA has been actively engaging with CMS to try and mitigate disruptions to patient coverage and access
 - AMA has developed a slew of resources available at ama-assn.org/OB3
 - Medicaid provider tax reform:
 - On Jan. 29, CMS [finalized a rule](#) to end certain types of Medicaid provider taxes used to finance state Medicaid programs
 - See our [comment letter](#) to CMS >>
 - There’s another pending proposed rule on the hold harmless threshold at OMB
 - Accelerating State Pediatric Innovation Readiness and Effectiveness (ASPIRE) Model for youth up to age 21 who either have or are at risk of developing complex medical and behavioral needs.
- Affordable Care Act (ACA)
 - 2027 ACA proposed rule included several changes that would generally ease coverage requirements in an effort to increase affordability.
 - AMA [comments](#) pushed back on several proposals including counting non-network plans as qualified health professionals (QHPs), expanding access to catastrophic plans, reducing in-network essential provider and network adequacy standards, and allowing bronze and catastrophic cost sharing to exceed out of pocket limits. In our letter we reiterate the importance of maintaining access to coverage that is affordable and comprehensive, warn of the potential impact on adverse selection and affordability for older and sicker Americans, and call for additional guardrails and delays.
 - Final rule is under review at OMB as of April 1, 2026.
- No Surprises Act (NSA) Implementation
 - AMA Federation [sign-on letter](#) to Elevance Health calling on them to rescind an automatic 10% reimbursement cut to a hospital when out-of-network physicians are used.
 - AMA sent letters to the [House](#) and [Senate](#) in support of NSA Enforcement Act.
 - AMA commented on a [proposed rule](#) that included several AMA asks to improve Independent Dispute Resolution (IDR) process. Rule was proposed Oct. 2023; now (finally) under OMB review.
 - In June 2025, the US Court of Appeals for the Fifth Circuit held that providers do not have a private right of action to enforce dispute resolution awards under the NSA in [Guardian Flight LLC et al. v. Health Care Service Corp.](#) The AMA submitted an amicus brief in support of Guardian Flight.
 - Have received many examples of payer non-compliance. More to come on that VERY soon. Send more examples to Suzanne.joy@ama-assn.org.
- Medicare Telehealth Updates
 - 2026 Medicare physician payment rule changes:
 - made virtual supervision & lifting of frequency limits on telehealth visits permanent

- physicians providing telehealth do not have to report their home address to Medicare unless they do not have an office
 - Consolidated Appropriations Act, 2026 changes (signed 2/3/26):
 - extended Medicare telehealth flexibilities for two years until December 31, 2027
 - extended Acute Hospital Care at Home Program through 2030
 - To achieve permanent Medicare telehealth coverage, AMA supports the bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 1261/H.R. 4206)
- Healthcare Pricing & Affordability
 - Drug pricing has become a key focus, with several new drug-focused CMMI models; the administration executing several Most Favored Nation agreements and putting pressure on drug manufacturers through tariffs; and MedPAC emphasizing drug pricing as a key driver of U.S. healthcare costs.
 - Healthcare consolidation: Updated AMA [research](#) shows the potential harms of vertical and horizontal consolidation on patient choice, affordability, and access to care. HHS released a [report](#) detailing responses to an RFI on the topic. In their March [report](#), MedPAC noted how Medicare payment policy is driving consolidation (physicians remain the only Medicare provider without an inflation-based update).
 - Administrative burden reduction remains a core focus for the AMA and this administration. Last year, there was a series of RFIs on the topic to which the AMA responded. The AMA will continue to push for MIPS and prior auth reforms to reduce admin burden and even the playing field for independent practice.
 - Fraud: Several Congressional hearings on the topic. CMS “CRUSH” RFI (Comprehensive Regulations To Uncover Suspicious Healthcare) covered several topic areas. Read AMA’s [response](#) >>
- Make America Healthy Again (MAHA)/Nutrition
 - Medical School Commitments to Increase Nutrition Training for Future Doctors: In March 2026 AMA President Doctor Bobby Mukkamala joined HHS Secretary Kennedy and Secretary of Education Linda McMahon and other healthcare leaders to [launch](#) a new initiative with 53 of the nation’s top medical schools that have committed to providing at least 40 hours of nutrition education for students starting in the fall of 2026.
 - The AMA has launched a Healthy Diet and Dietary Patterns [Webinar Series](#)
 - Internal AMA nutrition education steering committee
 - 2026-2030 Dietary Guidelines [released](#) in January
 - See [AMA statement](#) which outlines several commitments
 - Medicare Diabetes Prevention Program: AMA is actively engaged with CMS Medicare Diabetes Prevention Program (MDDP) staff to promote several recent changes to expand the program’s reach, including allowing virtual only suppliers, removing the once per lifetime limit, and covering A1c testing to screen for prediabetes and Type 2 Diabetes.
 - Mandatory Front of Package Labeling: Last year, the FDA [issued](#) a proposed rule, which the AMA [commented on](#). Final rule is still TBD (not yet at Office of Management and Budget (OMB)).

Homework

- Physicians Grassroots Advocacy Network
 - Urge your members of congress to fix Medicare now
 - Tell congress to fix prior authorization
 - Tell congress: protect America's most vulnerable patients
 - Ask congress to help stop H-1B visa fees
 - <https://physiciansgrassrootsnetwork.org/advocacy-hub>
- Ms. Joy and Mr. Hull addressed the following question:
 - A member inquired about the status of the H-1B Physician & Healthcare Workforce Act (H.R. 7961) bill that will exempt physicians and other healthcare professionals from the \$100,000 H-1B fee in the US House of Representatives and US Senate respectively. Mr. Hull responded that the AMA responded with the AMA sign-on letter in April 2026 and the AMA is looking to introduce a Senate companion bill on the H-1B issue.

IX. Relative Value Recommendations for CPT 2027

Adjacent Tissue Transfer (Tab 4)

Brian Boyce, MD (AAO-HNS), Christopher Childers, MD (ACS), Jeff Kozlow, MD (ASPS), Howard Rogers, MD (AADA), Walton Taylor, MD (ASBrS), Thomas Willson, MD (ASPS)

The adjacent tissue transfer (ATT) code family represents a series of reconstructive procedures in which local tissue is transposed, rotated, or advanced to fill an adjacent defect. The surgical work requires making additional incisions, preserving vascularity, and then appropriately transferring the tissue to the primary defect, with closure of the donor site. This code family has been present in CPT since before 1992, the year of implementation of the Resource-Based Relative Value Scale (RBRVS). In 1996, CMS/CCI added procedure-to-procedure (PCP) edits to provide consistency between the ATT codes and the benign/malignant excision codes and how to report these services. In 2007, the Academy of Plastic Surgeons (ASPS) submitted a CPT Code Change Application (CCA) to add further clarifying language (consistent with current CPT instructions) that the excision of a benign or malignant cutaneous lesion is not separately reportable with an adjacent tissue transfer or rearrangement.

In January 2024, the CPT Editorial Panel recommended that the specialty societies submit a CCA for the code family to address a coding gap that was identified. Specifically, there was no CPT code to report an adjacent tissue transfer when it does not involve the excision of a lesion. In January 2026, the specialty societies submitted a subsequent CCA, which addressed this concern by simply updating the introductory language within the benign lesion, malignant lesion, and adjacent tissue transfer and arrangement sections to remove references to the benign or malignant excision codes being bundled with the adjacent tissue transfer codes. Under the legacy CPT introductory guidelines, the work of performing the excision of a benign lesion ([11400]-[11446]) or a malignant lesion ([11600]-[11646]) on the same date as ATT codes ([14000]-[14302]) was bundled into the ATT codes. Under the new coding structure, the excision of a benign or malignant lesion will newly become separately reportable. The specialty societies explained that performing a same-day excision is not typical in clinical practice and is expected to be rare once excisions can be separately reported.

The ATT code family consists of ten codes. For smaller area procedures, CPT codes 14000-14061 are separated into four anatomic areas of increasing intensity/complexity and sensitivity, with a paired small code (defects less than 10.0 square centimeters) and large code (defects between 10.1-30.0

square centimeters). For adjacent tissue transfer/rearrangement larger than 30 square centimeters, there is a base add-on CPT code 14301 (defects between 30.1-60.0 square centimeters) and a subsequent add-on CPT code (for each additional 30 square centimeters). These two codes replaced the previous CPT code 14300 in order to better delineate the work of a larger area adjacent tissue transfer. This entire code family was surveyed for the April 2026 RUC meeting.

Compelling Evidence

The specialty societies presented compelling evidence based on two arguments. First, there was a change in the primary specialty society performing six of these services, including CPT codes 14000, 14001, 14020, 14021, 14041, and 14061, all of which were part of the Phase III Harvard study, which were surveyed by 16 plastic surgeons and no other specialty societies. These services have never been surveyed for review

by the RUC. Current 2024 Medicare claims data shows that Plastic Surgery is no longer the primary specialty society performing these services and has been replaced by Mohs Dermatologic Surgeons (MDS) (or, as classified by CMS, Micrographic Dermatologic Surgery) (subspecialty trained by Dermatologists) and both Breast Surgeons/Surgical Oncologists (subspecialty trained by General Surgeons).

Code	2024 Plurality/Majority Specialty	Spec %
14000	Dermatology/Mohs Dermatologic Surgeons	32.3%
14001	General Surgery /Surgical Oncology	43.1%
14020	Dermatology/ Mohs Dermatologic Surgeons	48.0%
14021	Dermatology/ Mohs Dermatologic Surgeons	60.1%
14041	Dermatology/ Mohs Dermatologic Surgeons	71.1%
14061	Dermatology/ Mohs Dermatologic Surgeons	70.8%

Second, the specialty societies presented an argument that flawed methodology was used in a previous valuation for some of these services. CPT codes 14001, 14020, 14021, 14041, and 14061 were identified by the Relativity Assessment Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007 (CPT codes 14000, 14020, 14040, and 14060 from the code family were also included). These codes were flagged as having a site of service anomaly, where an office-based procedure had a corresponding hospital post-operative visit. At that time, the decision was made to remove all the associated hospital visits and values through a reverse/negative-building block method for these services, which is no longer an accepted/valid methodology. The specialties acknowledged that the current RUC process requires that, for site of service anomalies, a formal survey of the entire code family be conducted for magnitude estimation. Outside of codes currently valued through a building block methodology, both CMS and RUC have only used post-procedure hospital and outpatient clinic values as proxies for magnitude estimation, not as discrete work RVU values. Removing the entire associated work RVU for an E/M visit from code is only appropriate if a building block methodology was used to initially add the associated E/M visits, and notably, the hospital visits for these six codes were imputed by the CMS contractor in 1997. **The RUC agreed there is compelling evidence that there has been a change in the primary specialty society and that a flawed methodology was used in a previous valuation for these services.**

Anomalous Relationship within the Code Family

Given the variation in how each code in this family arrived at its current work RVU and times, the specialty societies addressed the anomalous relationships across the codes in this family, especially in the time elements. Importantly, CPT codes 14000, 14001, 14020, 14021, 14041, and 14061 have never been RUC-surveyed. Instead, these six services received an initial Harvard valuation, followed by contractor-converted times to E/M/Hospital components, followed by a reverse/negative-building

block methodological removal of hospital visit value. Conversely, the other four services in this family, CPT codes 14040, 14060, 14301, and 14302, have all been surveyed for review by the RUC, but not in the last 15+ years, and never as a complete code family. Notably, the vignettes used during these respective surveys described a patient presenting with a previously performed excision, and not that an excision was part of the physician work associated with these services.

The specialty societies acknowledged that the current work RVU rank order is appropriate and maintains overall relativity within the code family. Codes describing larger defects require slightly more physician work due to the increase in size, but also due to the general clinical assumption that as the size of the reconstruction increases, so too does the overall intensity/complexity. Moreover, the amount of physician work, time, and intensity/complexity increases as the sensitivity escalates in each anatomic area, as presented in current code structure starting with the trunk/torso (CPT codes 14000 & 14001), and increasing across each anatomic code pair in the family, including scalp/arms/legs (CPT codes 14020 & 14021), forehead/cheeks/chins/etc. (CPT codes 14040 & 14041), and eyelids/nose/ears/lips (CPT codes 14060 & 14061). However, the underlying times are problematic based on the varied history of how each has been derived. The inconsistency in the intra-times and total times is especially notable between related code pairs from the same anatomic area, and the lack of a consistent relationship across the code family. These inaccurate times have subsequently resulted in anomalous intensity measures that are also very inconsistent across the family. Performing a single survey of the entire family allows for rectification of these elements.

Changes in post-operative work

The specialty societies also identified that the current work RVU values are from before the 2021 E&M revisions in description and work valuation. The subsequent changes in post-operative work and valuation reflected in the survey support the very small proposed increases in work RVU from the current values.

14000 *Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less*

The RUC reviewed survey results from 245 physicians and recommends the survey 25th percentile work RVU of 6.40, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 20 minutes of immediate post-service time, and 3-99213 post-operative office visits, which equals 172 minutes of total time.

CPT code 14000 has never been surveyed for review by the RUC; it describes an adjacent tissue transfer or rearrangement where a defect of 10 square centimeters or less is located on the patient's trunk/torso. Given that 68% of survey respondents stated this service is performed in the office (compared to 55% of claims data), the specialty societies selected pre-service time package *6-NF Proc w local/topical anes care req wait time* and post-service time package *7B Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, the overall physician work and intensity/complexity involved with this size of defect on the trunk/torso is less than larger defect reconstructions or compared to other more sensitive anatomic areas. Additionally, the RUC agreed that three post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure.

To support the recommended work RVU of 6.40, the RUC compared the surveyed code to the top key reference service 21552 *Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater* (work RVU = 6.33, 58.5 minutes of intra-service time, 192.5 minutes of total time) and the second key reference service 21014 *Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater* (work RVU = 6.95, 58.5 minutes of intra-service time, 215.5 minutes of total time), which both require similar intra-service time and together bracket the survey 25th percentile work RVU.

For additional support, the RUC referenced CPT code 15771 *Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate* (work RVU = 6.56, 58.5 minutes of intra-service time, 179.5 minutes of total time), which requires similar intra-service and total time compared to the surveyed code. The reference code requires more physician work and is more intense/complex to perform and thus is valued slightly higher than the surveyed code. The RUC recognizes that the median survey intra-service time represents a decrease from the current times and that the survey 25th percentile work RVU is an increase from the current value; however, since this service has never been surveyed for review by the RUC, and the old time data and values assigned to these procedures resulted in anomalously low intensities, current valid survey results as indicated by physicians who perform these services should be used to accurately value this service.

Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the Medicare Physician Payment Schedule (MFS). **The RUC recommends a work RVU of 6.40 for CPT code 14000.**

14001 *Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm*

The RUC reviewed survey results from 248 physicians and recommends the survey 25th percentile work RVU of 8.61, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 75 minutes of intra-service time, 21 minutes of immediate post-service time, 0.5-99238 discharge visit, and 3-99213 post-operative office visits, which equals 235 minutes of total time.

CPT code 14001 has never been surveyed for review by the RUC; it describes an adjacent tissue transfer or rearrangement where the defect located on a patient's trunk/torso is between 10.1 and 30.0 centimeters. While 62% of survey respondents stated this service is performed in the office, the specialty societies noted that this might be attributed to the increased response rate of dermatologists compared to the other surgical specialty societies. Claims data from 2024 show that this service is performed in the facility 62% of the time. The specialty societies selected pre-service time package 3-*FAC Straightforward Patient/Difficult Procedure* and post-service time package 9A *General Anes or Complex Reg Blk/Srgtforw Proc* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results. Moreover, the RUC agreed that including a 0.5-99328 discharge visit is appropriate for procedures performed in a facility with a typical same-day evaluation prior to discharge.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, the overall physician work and intensity/complexity are less for surgery on the trunk/torso than it is for other more sensitive anatomic areas. Compared to the paired code for this anatomic area (CPT code 14000), the surveyed code appropriately requires more intra-service, total time, and overall physician work, as it is more intense/complex to perform, given the increased size of the defect and the larger reconstruction necessary. Additionally, the RUC agreed that three post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for

wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure.

To support the recommended work RVU of 8.61, the RUC compared the surveyed code to the top key reference service 26480 *Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon* (work RVU = 8.78, 58.5 minutes of intra-service time, 261.5 minutes of total time) and the second key reference service 15576 *Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral* (work RVU = 9.14, 87.75 minutes of intra-service time, 268.8 minutes of total time). CPT code 26480 requires less intra-service time, but more overall physician work and total time (including a level 4 office visit) compared to the surveyed code, since it involves a more intense transfer/transplant of a tendon in the hand compared to a tissue transfer/rearrangement on the trunk/torso. CPT code 15576 requires more intra-service time, total time, and physician work overall, and thus has a greater work RVU than the surveyed code.

For additional support, the RUC referenced CPT code 27048 *Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 8.63, 73.13 minutes of intra-service time, 286.13 minutes of total time). Compared to the surveyed code, reference CPT code 27048 requires similar overall physician work and similar intra-service time, despite differences in total time and intensity/complexity. The RUC recognizes that the median survey intra-service time represents a decrease from the current times and that the survey 25th percentile work RVU is an increase from the current value; however, since this service has never been surveyed for review by the RUC, and the old time data and values assigned to these procedures resulted in anomalously low intensities, current valid survey results as indicated by physicians who perform these services should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 8.61 for CPT code 14001.**

14020 *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less*

The RUC reviewed survey results from 280 physicians and recommends the survey 25th percentile work RVU of 7.20, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 63 minutes of intra-service time, 20 minutes of immediate post-service time, and 3-99213 post-operative office visits, which equals 175 total minutes.

CPT code 14020 has never been surveyed for review by the RUC; it describes an adjacent tissue transfer or rearrangement where a defect of 10 square centimeters or less is located on the patient's scalp, arms, and/or legs. Given that 64% of survey respondents stated this service is performed in the office (compared to 79% of claims data), the specialty societies selected pre-service time package 6-*NF Proc w local/topical anes care req wait time* and post-service time package 7B *Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work and greater intensity/complexity involved with this size of defect and reconstruction on the scalp/arms/legs compared to surgery on the trunk/torso (CPT code 14000). While the surveyed code is more intense/complex, it involves less physician work overall to perform this service compared to larger trunk/torso defects (CPT codes 14001) and compared to other more sensitive anatomic areas described in this code family. Additionally, the RUC agreed that three post-operative office visits are typically required for this outpatient service, primarily to monitor and

evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure.

To support the recommended work RVU of 7.20, the RUC compared the surveyed code to the top key reference service 17108 *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm* (work RVU = 7.30, 58.5 minutes of intra-service time, 146.5 minutes of total time). The surveyed code requires greater intra-service time and less physician work overall than CPT code 17108, which describes a higher intensity procedure for large lesion removals.

For additional support, the RUC referenced CPT code 23076 *Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 7.22, 58.5 minutes of intra-service time, 219.5 minutes of total time), which requires slightly less intra-service time and similar physician work overall. However, the surveyed code requires less total time but requires more intensity/complexity than the reference service based on the anatomic location of the procedure and size of the excision compared to the ATT work of the surveyed code. The RUC recognizes that the median survey intra-service time represents a decrease from the current times and that the survey 25th percentile work RVU is an increase from the current value; however, since this service has never been surveyed for review by the RUC, and the old time data and values assigned to these procedures resulted in anomalously low intensities, current valid survey results as indicated by physicians who perform these services should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 7.20 for CPT code 14020.**

14021 *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm*

The RUC reviewed survey results from 280 physicians and recommends the survey 25th percentile work RVU of 9.50, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 83 minutes of intra-service time, 21 minutes of immediate post-service time, and 4-99213 post-operative office visits, which equals 219 total minutes.

CPT code 14021 has never been surveyed for review by the RUC; it describes an adjacent tissue transfer or rearrangement where the defect located on a patient's scalp/arms/legs is between 10.1 and 30.0 centimeters. Given that 56% of survey respondents stated this service is performed in the office (compared to 78% of claims data), the specialty societies selected pre-service time package 6-NF *Proc w local/topical anes care req wait time* and post-service time package 7B *Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work and greater intensity/complexity for large surgical reconstructions on the scalp/arms/legs involved in this service, compared to surgery for small and large defects located on the trunk/torso (CPT codes 14000 and 14001). Compared to the paired code for this anatomic area (CPT code 14020), the surveyed code appropriately requires more intra-service, total time, and overall physician work, as it is more intense/complex to perform, given the increased size of the defect and the larger reconstruction necessary. However, this service is still less intense/complex and requires less physician work compared to other, more sensitive anatomic areas described in this code family. Additionally, the RUC agreed that four post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue

viability, infection, bleeding, and potential impact on regional anatomy from the procedure. An additional post-operative office visit is required for this service, typically at 90 days post-procedure, to evaluate the outcome and impact on functional elements of the patient's recovery, particularly because the scalp/arms/legs are in a more public area compared to the trunk/torso.

To support the recommended work RVU of 9.50, the RUC compared the surveyed code to the top key reference service 67902 *Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)* (work RVU = 9.57, 76.05 minutes of intra-service time, 219.05 minutes of total time). The surveyed code requires more intra-service and total time than the surveyed code, but appropriately has a lower work RVU, given it is less intense/complex to perform based on the physician work described in the reference service.

The RUC recognizes that the median survey intra-service time represents a decrease from the current times and that the survey 25th percentile work RVU is an increase from the current value; however, since this service has never been surveyed for review by the RUC, and the old time data and values assigned to these procedures resulted in anomalously low intensities, current valid survey results as indicated by physicians who perform these services should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 9.50 for CPT code 14021.**

14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

The RUC reviewed survey results from 281 physicians and recommends the survey 25th percentile work RVU of 8.50, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 75 minutes of intra-service time, 21 minutes of immediate post-service time, and 4-99213 post-operative office visits, which equals 211 total minutes.

CPT code 14040 was last surveyed for review by the RUC in August 2005; it describes an adjacent tissue transfer or rearrangement where a defect of 10 square centimeters or less is located on the patient's forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet. Given that 62% of survey respondents stated this service is performed in the office (compared to 71% of claims data), the specialty societies selected pre-service time package *6-NF Proc w local/topical anes care req wait time* and post-service time package *7B Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work involved with surgical reconstruction for smaller defects on the forehead/cheeks/chin/etc. compared to reconstruction for smaller defects on the trunk/torso or the scalp/arms/legs (CPT codes 14000 and 14020, respectively). However, less physician work is required to perform this service compared to the larger trunk/torso and scalp/arms/legs defects (CPT codes 14001 and 14021, respectively), as well as other more sensitive areas described in this code family. Additionally, the RUC agreed that four post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure. A fourth post-operative office visit is required for this service, typically at 90 days post-procedure, to evaluate the outcome and impact on functional elements of the patient's recovery, particularly because the forehead/cheeks/chin/etc. are in a more public area compared to the trunk/torso.

To support the recommended work RVU of 8.50, the RUC compared the surveyed code to reference CPT codes 19330 *Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)* (work RVU = 8.78, 73.13 minutes of intra-service time, 227.13 minutes of total time) and 57282 *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)* (work RVU = 11.34, 85.8 minutes of intra-service time, 226.8 minutes of total time). CPT code 19330 requires similar intra-service time compared to the surveyed code. Both services require more physician work, total time overall, and a greater work RVU, which is appropriate given that both reference services require more intensity/complexity.

The RUC recognizes that the median survey intra-service time represents a decrease from the current times and that the survey 25th percentile work RVU is an increase to the current value; however, this service has not been surveyed for review by the RUC in approximately 20 years and has never been surveyed at the same time as all the other codes in this family. Moreover, the old time data and values assigned to these procedures resulted in anomalously low intensities, so current valid survey results, as indicated by physicians who perform these services, should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 8.50 for CPT code 14040.**

14041 *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm*

The RUC reviewed survey results from 281 physicians and recommends maintaining the current value work RVU of 10.56, which is also the survey 25th percentile work RVU and appropriately accounts for the physician work typically required to perform this service. RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time, 21 minutes of immediate post-service time, 1-99214 post-operative office visits, and 3-99213 post-operative office visits, which equals 243 total minutes.

CPT code 14041 has never been surveyed for review by the RUC; it describes an adjacent tissue transfer or rearrangement where the defect located on the patient's forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet is between 10.1 and 30.0 centimeters. Given that 56% of survey respondents stated this service is performed in the office (compared to 78% of claims data), the specialty societies selected pre-service time package *6-NF Proc w local/topical anes care req wait time* and post-service time package *7B Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work and greater intensity/complexity for surgical reconstructions of large defects on the forehead/cheeks/chin/etc. compared to surgery for small and large defects on the trunk/torso or on the scalp/arms/legs (CPT codes 14000 & 14001 and 14020 & 14021, respectively). Compared to the paired code for this anatomic area (CPT code 14040), the surveyed code appropriately requires more intra-service time, total time, and overall physician work, as it is more intense/complex to perform, given the increased size of the defect and the larger reconstruction necessary. However, this service requires less physician work and is less intense/complex to perform compared to other, more sensitive anatomic areas described in this code family.

Additionally, the RUC agreed that four post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure. A fourth post-operative office visit is required for this service, typically at 90 days post-procedure, to evaluate

the outcome and impact on functional elements of the patient's recovery, particularly because the forehead/cheeks/chin/etc. are in a more public area compared to the trunk/torso. Furthermore, the RUC also agreed that a Level 4 office visit is appropriate based on the level of medical decision-making and risks for the patient associated with this service.

To support the recommended work RVU of 10.56, the RUC compared the surveyed code to the second key reference service, CPT code 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.16, 87.75 minutes of intra-service time, 253.25 minutes of total time). The surveyed code requires similar intra-service time but slightly less total time and less physician work overall, as CPT code 15730, which is a significantly more intense procedure to perform that involves a midface flap due to a displaced eyelid.

For additional support, the RUC referenced CPT code 64823 *Sympathectomy; superficial palmar arch* (work RVU = 10.67, 87.75 minutes of intra-service time, 296.75 minutes of total time), which requires similar intra-service time as the surveyed code. Reference CPT code 64823 is a higher-intensity procedure that requires slightly more total time and more physician work overall compared to the surveyed code. The RUC recognizes that the median survey intra-service time represents a decrease from the current times; however, since this service has never been surveyed for review by the RUC, maintaining the current value despite a decrease in intra-service time is reasonable. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends the current work RVU of 10.56 for CPT code 14041.**

14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less*

The RUC reviewed survey results from 284 physicians and recommends the survey 25th percentile work RVU of 9.14, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 75 minutes of intra-service time, 21 minutes of immediate post-service time, 1-99214 post-operative office visits, and 3-99213 post-operative office visits, which equals 228 total minutes

CPT code 14060 was last surveyed for review by the RUC in August 2005; it describes an adjacent tissue transfer or rearrangement where a defect of 10 square centimeters or less is located on the patient's eyelids, nose, ears, and/or lips. Given that 56% of survey respondents stated this service is performed in the office (compared to 78% of claims data), the specialty societies selected pre-service time package 6-NF *Proc w local/topical anes care req wait time* and post-service time package 7B *Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work involved with reconstructions for small defects on the eyelids/nose/ears/lips. compared to reconstructions for small or large defects on the trunk/torso, or small defects on the scalp/arms/legs, or the forehead/cheeks/chin/etc. (CPT codes 14000 & 14001, 14020, and 14040, respectively). However, less physician work is required to perform this service compared to the larger defects on the scalp/arms/legs, or forehead/cheeks/chin/etc. (CPT codes 14021 and 14041, respectively), as well as other more sensitive areas described in this code family. Additionally, the RUC agreed that four post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure. A fourth post-operative office visit is required for this service, typically at 90 days post-procedure, to evaluate the outcome

and impact on functional elements of the patient's recovery, particularly because the forehead/cheeks/chin/etc. are in a more public area compared to the trunk/torso. Furthermore, the RUC also agreed that a level 4 office visit is appropriate based on the level of medical decision-making and risks for the patient associated with this service.

To support the recommended work RVU of 9.14, the RUC compared the surveyed code to the second key reference service 67902 *Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)* (work RVU = 9.57, 76.05 minutes of intra-service time, 219.1 minutes of total time). The surveyed code requires similar intra-service and total time as the reference service despite having a lower work RVU, which is attributed to CPT code 67092 being a higher intensity ophthalmologic surgery to perform.

For additional support, the RUC referenced CPT code 19370 *Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy* (work RVU = 8.94, 76.05 minutes of intra-service time, 253.05 minutes of total time), which requires similar intra-service time as the surveyed code. The surveyed code requires more physician work, which is attributable to the greater intensity/complexity of the physician work involved with this service. The RUC recognizes that the median survey intra-service time represents an increase from the current times and that the survey 25th percentile work RVU is an increase to the current value; however, this service has not been surveyed for review by the RUC in approximately 20 years and has never been surveyed at the same time as all the other codes in this family. Moreover, the old time data and values assigned to these procedures resulted in anomalously high intensities, so current valid survey results, as indicated by physicians who perform these services, should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 9.14 for CPT code 14060.**

14061 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm*

The RUC reviewed survey results from 277 physicians and recommends the survey 25th percentile work RVU of 11.21, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 17 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 100 minutes of intra-service time, 21 minutes of immediate post-service time, 1-99214 post-operative office visits, and 3-99213 post-operative office visits, which equals 253 total minutes.

CPT code 14061 has never been surveyed for review by the RUC; it describes an adjacent tissue transfer or rearrangement where the defect located on the patient's eyelids, nose, ears, and/or lips is between 10.1 and 30.0 centimeters. Given that 56% of survey respondents stated this service is performed in the office (compared to 76% of claims data), the specialty societies selected pre-service time package 6-NF *Proc w local/topical anes care req wait time* and post-service time package 7B *Local/Complex Procedure* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work and greater intensity/complexity for surgical reconstructions of small or large defects on the eyelids/nose/ears/lips compared to work on the trunk/torso, scalp/arms/legs, or forehead/cheeks/chin/etc. (CPT codes 14000 & 14001, 14020 & 14021, and 14040 & 14041, respectively). Compared to the paired code for this anatomic area (CPT code 14060), the surveyed code appropriately requires more intra-service time, total time, and overall physician work, as it is more intense/complex to perform given the increased size of the defect and the larger reconstruction

necessary. However, this service requires less physician work and time compared to the extra-large defects and reconstructions (CPT code 14301).

Additionally, the RUC agreed that four post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure. A fourth post-operative office visit is required for this service, typically at 90 days post-procedure, to evaluate the outcome and impact on functional elements of the patient's recovery, particularly because the forehead/cheeks/chin/etc. are in a more public area compared to the trunk/torso. Furthermore, the RUC also agreed that a level 4 office visit is appropriate based on the level of medical decision-making and risks for the patient associated with this service.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference service 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.16, 87.75 minutes of intra-service time, 253.3 minutes of total time) and second key reference service 15576 *Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral* (work RVU = 9.14, 87.75 minutes of intra-service time, 268.8 minutes of total time), which together support the survey 25th percentile work RVU. The surveyed code requires more intra-service time than both reference services, identical total time as the top key reference service, and comparable overall intensity/complexity based on the description of the typical physician work associated with this service.

The RUC recognizes that the median survey intra-service time represents a decrease from the current times and that the survey 25th percentile work RVU is an increase from the current value; however, since this service has never been surveyed for review by the RUC, and the old time data and values assigned to these procedures resulted in anomalously low intensities, current valid survey results as indicated by physicians who perform these services should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 11.21 for CPT code 14061.**

14301 *Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm*

The RUC reviewed survey results from 278 physicians and recommends the survey 25th percentile work RVU of 12.50, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 115 minutes of intra-service time, 30 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99214 post-operative office visit, and 3-99213 post-operative office visits, which equals 324 total minutes.

CPT code 14301 was last surveyed for review by the RUC in April 2009; it describes an adjacent tissue transfer or rearrangement for extra-large defects between 10.1 and 30.0 centimeters located in any area of the body. While 54% of survey respondents stated this service is performed in the office, the specialty societies noted that this might be attributed to the increased response rate of dermatologists compared to the other surgical specialty societies. Medicare claims data from 2024 show that this service is performed in the facility 61% of the time. The specialty societies selected pre-service time package 3-*FAC Straightforward Patient/Difficult Procedure* and post-service time package 9A *General Anes or Complex Reg Blk/Strghtforw Proc* for this service. The RUC agreed with these time package selections and the slight modifications made to align with survey results. Moreover, the RUC agreed that including a 0.5-99328 discharge visit is appropriate for procedures performed in a facility with a typical same-day evaluation prior to discharge.

Compared to the other anatomic areas for adjacent tissue transfer described in this code family, there is more physician work involved with surgical reconstructions of these extra-large defects located in any anatomic area compared to surgery for small or large defects for any of the paired codes in this code family. Though this service does not have the greatest intensity/complexity in this code family, it does involve the most physician work and requires the most intra-service and total time.

Additionally, the RUC agreed that four post-operative office visits are typically required for this outpatient service, primarily to monitor and evaluate the surgical site for wound healing, tissue viability, infection, bleeding, and potential impact on regional anatomy from the procedure. A fourth post-operative office visit is required for this service, typically at 90 days post-procedure, to evaluate the outcome and impact on functional elements of the patient's recovery, particularly of the larger size of the surgical site and impact on functional/aesthetic outcomes. Furthermore, the RUC also agreed that a level 4 office visit is appropriate based on the level of medical decision-making and risks for the patient associated with this service.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference service 19303 *Mastectomy, simple, complete* (work RVU = 14.63, 87.75 minutes of intra-service time, 280.8 minutes of total time). Though the surveyed code requires more total time, it involves less intra-service time and less physician work overall (and smaller work RVU), which is attributable to the top key reference code describing the physician work of performing a mastectomy, which is significantly more intense/complex to perform.

For additional support, the RUC referenced CPT code 24545 *Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension* (work RVU = 12.82, 117 minutes of intra-service time, 358 minutes of total time), which requires similar intra-service time as the surveyed code. CPT code 24245 requires more total time than the surveyed code, but the two services require similar intensity/complexity, making it an appropriate comparison. The RUC recognizes that the median survey intra-service time represents an increase from the current times and that the survey 25th percentile work RVU is an increase to the current value; however, this service has not been surveyed for review by the RUC in approximately 17 years and has never been surveyed at the same time as all the other codes in this family. Moreover, the old time data and values assigned to these procedures resulted in anomalously low intensities, so current valid survey results, as indicated by physicians who perform these services, should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 12.50 for CPT code 14301.**

14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)*

The RUC reviewed survey results from 264 physicians and recommends maintaining the current work RVU of 3.64, which is below the survey 25th percentile and appropriately accounts for the physician work typically required to perform this ZZZ add-on service. The RUC recommends 45 minutes of intra-service and total time.

CPT code 14302 was last surveyed for review by the RUC in April 2009; it describes each additional 30.0 centimeters for an adjacent tissue transfer or rearrangement for extra-large defects that are between 30.1 – 60.00 square centimeters located in any area of the body.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference service 49623 *Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie,*

open, laparoscopic, robotic) (List separately in addition to code for primary procedure) (work RVU = 3.66 and 43.88 minutes of intra-service and total time), which requires similar intra-service time and overall physician work as the surveyed code.

For additional support, the RUC referenced CPT code 15777 *Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)* (List separately in addition to code for primary procedure) (work RVU = 3.56 and 43.88 minutes of intra-service and 48.88 total time), which requires similar intra-service time but slightly less physician work overall than the surveyed code. The RUC recognizes that the median survey intra-service time represents an increase from the current times but recommends current value instead of the survey 25th percentile work RVU to maintain better relativity, as this service has not been surveyed for review by the RUC in approximately 17 years and has never been surveyed at the same time as all the other codes in this family. Moreover, the old time data and values assigned to these procedures resulted in anomalously low intensities, so current valid survey results, as indicated by physicians who perform these services, should be used to accurately value this service. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across the MFS. **The RUC recommends the current work RVU of 3.64 for CPT code 14302.**

Practice Expense

The Practice Expense (PE) Subcommittee concurred that there is compelling evidence to support an increase over the aggregate current cost for clinical staff time, supplies, and equipment for the code family based on a change in technique and flawed methodology, as most of the codes in the family have never been surveyed or undergone review by the PE Subcommittee. The recommendations bring the Adjacent Tissue Transfer codes in line with current practice.

The Subcommittee reviewed the direct practice expense inputs and made one modification to the equipment inputs. The PE Subcommittee replaced EF014 *light, surgical* with EQ168 *light, exam* for post-operative clinical staff time. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Goniotomy (Tab 5)

Matthew Appenzeller, MD (AAO), Nina Goyal, MD (AAO), Sue Hewitt, MD (ASCRS), Bryan Lee, MD (ASCRS), Ravi Parikh, MD (AAO), Daniel Vu, MD (AAO)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 65820 *Goniotomy* via the high-volume growth screen, with Medicare utilization over 10,000, which has increased by at least 100% from 2018 through 2023. In September 2025, after reviewing the specialty society action plan, the RUC recommended referring the issue to the February 2026 CPT Editorial Panel meeting to create a new Category I CPT code specific for stand-alone performance of goniotomy in adults and to modify the existing CPT code 65820 to clarify that the legacy code was intended and will remain for goniotomy in infants or children younger than 18 years of age. Utilization is anticipated to be rare for the revised code compared with the new code, which is anticipated to have over 34,000 Medicare claims reported annually. The code family was revised in accordance with the RUC referral, and both codes were surveyed for the April 2026 RUC meeting.

The RUC acknowledges that these recommendations as a family are budget neutral. However, the RUC was persuaded by the specialty societies that support a change in physician work for CPT code 65820 based on a documented change in technique. The physician work has changed since the initial Harvard valuation of 65820 in 1995. The prior description of intra-service work for 65820 stated that the incision is usually 180 degrees. The typical technique for performing pediatric goniotomy has changed to a 360-degree opening of the trabecular meshwork to offer the best success rate and

involves more physician work than the previous incision of up to 180 degrees. A recent meta-analysis demonstrated greater intraocular pressure reduction, decreased need for glaucoma medication, and higher surgical success rate with 360-degree trabeculotomy compared with traditional angle surgery in primary congenital glaucoma (Abbas, et al. J Glaucoma. 2026 Feb 23)¹.

The RUC compared the surveyed code to CPT code 65850 *Trabeculotomy ab externo* (work RVU = 11.11, 58.5 minutes intra-service time, and 231.5 minutes total time). The specialty societies explained that 65850 is used to report trabeculotomy ab externo and 65820 is used to report trabeculotomy ab interno, also known as goniotomy, performed from inside the eye. The external procedure requires a similar amount of physician work but utilizes a different surgical approach/technique. The RUC concurs that the physician work for this service has changed due to a change in technique.

65820 Goniotomy; infant or child younger than 18 years of age

The RUC reviewed the survey results from 67 ophthalmologists and determined that the survey 25th percentile work RVU of 11.00 appropriately accounts for the physician work involved in this service. CPT code 65820 was traditionally performed to surgically treat congenital, infantile, and childhood glaucoma. It is the legacy code for treating pediatric glaucoma. The RUC recommends 40 minutes pre-service evaluation time, 3 minutes positioning time, 15 minutes scrub/dress/wait time, 35 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge day management visit, and 5-99213 office visits, for 247 minutes total time as supported by the survey.

The RUC noted that the surveyed code has never been RUC-valued, denoting that the current times are over 30 years old from the Harvard study, not surveyed, and are limited for comparison. The RUC discussed the high total time due to the five post-operative visits, all of which are level 3 visits. The specialty societies explained that these visits are typically performed in-clinic; one day, one week, 3 weeks, 6 weeks, and 10 weeks after surgery. At each visit, vision is assessed, the anterior segment is examined for hemorrhage and inflammation using a hand-held slit lamp or hand light, and intraocular pressure is measured with a tonometer. The fundus red reflex is assessed to judge degree of hemorrhage in the anterior and posterior segments. At one visit, typically 6 weeks after surgery, pupillary dilation is performed. Indirect ophthalmoscopy is performed to examine the vitreous, optic nerve, and central and peripheral retina. Refraction is checked for evidence of myopic shift. At every visit, postoperative medications, including intraocular pressure (IOP)-lowering medications and topical corticosteroids, are adjusted to manage intraocular pressure and inflammation. These visits typically include management of one acute problem with medication management decisions. At the dilated visit, amblyopia therapy may be adjusted. The societies also clarified that the post-operative visits are not typically performed under anesthesia, adding to the intensity as the physician must check the IOP and examine the eyes in awake infants, who typically resist examination of their eyes.

The RUC supports the number and level of post-operative visits recommended for the surveyed code as justified by the intensity of the procedure, which has become more complex since its last valuation, as described above. The pediatric goniotomy is an extremely intense procedure. The physician is cutting through 360 degrees of trabecular meshwork in the iridocorneal angle. In healthy infants, this tissue is under-developed and immature, with significant vasculature present (carrying a very high

¹ Abbas, Johar MBBS*; Haider, Faseeh MBBS†; Arooj, Hajira MBBS‡; Rustam, Zainab MBBS§; Srivastava, Saumya MBBS||; Haider, Haseeb MBBS¶; Makhija, Vatsal MBBS#; Srivastava, Saloni MBBS, MPH**; Binte Athar, Fatima MBBS††; Ahmed, Faizan MBBS‡‡; Arsalan, Zahra MBBS, FCPS, MRCS(Glasgow)§§; Wang, Bo MD, PhD|||. [Comparison of 360-Degree Trabeculotomy versus Traditional Angle Surgery in Primary Congenital Glaucoma: A Systematic Review and Meta-Analysis. Journal of Glaucoma](#) ():10.1097/IJG.0000000000002705, February 23, 2026. | DOI: 10.1097/IJG.0000000000002705

risk of significant bleeding and hyphema), and without iris pigmentation to delineate anatomic structures. The infant's iris develops pigmentation throughout the first year of life. In a 3-month-old, there is no color differentiation, and the physician performing the procedure is unable to use color and the normal pigmentation patterns to delineate anatomic landmarks to successfully manipulate tissue and avoid complications. The typical patient is born with a lens the same thickness as an adult's (despite the axial length of the pediatric eye being nearly a centimeter less than the adult eye), providing much less working space and a higher risk of damaging the lens. Impairing the lens is a serious vision-threatening risk in the amblyogenic stage of infancy and youth, unlike in an adult. All of the above risks are typical for a healthy infant, but this service is typically performed on infants with pathologic eyes. Hence, in addition to the age-related anatomic risks, these patients typically have anterior segment dysgenesis, which is the source of inadequate pressure control and glaucoma, and which leads to further intensity and risk. The anatomy is typically abnormal, with atypical iridocorneal structure, making the anatomic landmarks even more difficult to locate and manipulate surgically. All these variables (the limitations of normal infant development and the added risks of atypical development in the setting of pathology) render a high risk of significant bleeding (hyphema), severe anatomic disruption and even violating the lens capsule. Severe hyphemas are potentially vision-threatening in infants both as an amblyogenic source and as a cause of acute IOP elevation. If the lens and/or the lens capsule in a child is disrupted, it can cause permanent eye damage and risks blindness, again due to the amblyogenic developmental stage. Disrupted anatomy can limit future surgical rehabilitation options for the patient.

To justify a work RVU of 11.00, the RUC compared CPT code 65820 to the top key reference service code 66175 *Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent* (work RVU = 9.11, 29.25 minutes intra-service time and 183.25 minutes total time) and noted that the surveyed code has more intra-service and total time than the reference code and is therefore appropriately valued higher. Notably, two-thirds of the survey respondents who selected the top key reference code indicated that the surveyed code is more intense and complex to perform.

For additional support, the RUC compared the surveyed code to the second-highest key reference service code 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 12.87, 43.88 minutes intra-service time and 255.88 minutes total time) and to CPT code 66170 *Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery* (work RVU = 13.59, 43.88 minutes intra-service time and 276.88 minutes total time) noting that the surveyed code has less intra-service and total time than the reference codes and is therefore appropriately valued lower.

The RUC also referenced MPC code 67312 *Strabismus surgery, recession or resection procedure; 2 horizontal muscles* (work RVU = 9.26, 39 minutes intra-service time and 158 minutes total time) and noted relativity as the reference code is an ophthalmologic procedure on a two-year-old patient, therefore less physician work and total time, compared with the surveyed code for a 3-month old patient. Additionally, the surveyed code has more post-operative visits and total time.

The RUC noted that the survey respondents likely represent the majority of physicians performing this service across the country. With a valid survey that is well-bracketed with reference services. The RUC concluded that CPT code 65820 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 11.00 for CPT code 65820.**

65XX0 Goniotomy; adult

The RUC reviewed the survey results from 67 ophthalmologists and determined that a direct work RVU crosswalk to CPT code 67220 *Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions* (work RVU = 6.20, 14.63 minutes intra-service time and 117.13 minutes total time) maintains relativity within the code family and appropriately accounts for the physician work required for this service. Over the last ten years, the legacy code 65820 has been adopted for adult glaucoma surgery, with Medicare claims volume increasing from less than 200 claims prior to 2016 to 34,475 in 2024. It is likely that <1% of the Medicare claims are for pediatric goniotomy, and the remaining 99% are for adult goniotomy, which has become the most common case for goniotomy surgery. Medicare claims data indicates the legacy code (which is mostly adult patient utilization) was reported with cataract surgery over 90% of the time (CPT codes 66984, 66982, or 66991) and confirmed that the surveyed codes would be subject to the Multiple Procedure Payment Reduction (MPPR) if performed with the cataract codes.

The RUC recommends 13 minutes pre-service evaluation time, 1 minute positioning time, 6 minutes scrub/dress/wait time, 15 minutes intra-service time, 8 minutes immediate post-service time, 0.5-99238 discharge day management visit, and 4-99213 office visits, for 154 minutes total time as supported by the survey.

The RUC noted that the crosswalk code 67220 is an ophthalmologic procedure with similar intra-service time as the surveyed code. Both codes involve the placement of a lens on the surface of the eye to view and treat a disease that involves an intraocular structure that cannot be visualized with a microscope or the naked eye alone. Both 67220 and 65XX0 are of a high intensity because they are treating highly sensitive, difficult to visualize, and dynamic tissues. The central retina (67220) is responsible for all of one's high acuity vision, and the trabecular meshwork (65XX0) is a delicate tissue that determines intraocular pressure which causes optic nerve damage and vision loss when elevated. The crosswalk value results in an intensity measurement that is less than existing code 65820 as deemed appropriate given the higher intensity for the procedure in an infant. The surveyed code is routinely performed in an operating room with sedation and local anesthesia while the patient is awake. CPT code 65XX0 has one more post-operative visit than 67220, which is performed in the office and is non-incisional.

To justify a work RVU of 6.20, the RUC compared CPT code 65XX0 to the top key reference service code 66175 *Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent* (work RVU = 9.11, 29.25 minutes intra-service time and 183.25 minutes total time) and noted that the surveyed code has less intra-service and total time than the reference code and is less intense and is therefore appropriately valued lower. The RUC also compared the surveyed code to the second highest key reference service code 66711 *Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens* (work RVU = 5.48, 19.5 minutes intra-service time and 190.5 minutes total time) and noted that, although the surveyed code has less intra-service and total time than the reference code, it is far more intense. CPT code 65XX0 is directly excising tissue that can lead to bleeding/hyphema, intraocular pressure spikes and anatomic disruption of the anterior eye, whereas CPT 66175 is lasering tissue with lower levels of all these risks and is therefore appropriately valued higher.

For additional support, the RUC compared the surveyed code to CPT code 67210 *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (work RVU = 6.20, 14.63 minutes intra-service time and 105.63 minutes total time) and noted this ophthalmologic procedure requires similar intra-service time and is supportive of the crosswalk code. The RUC concluded that CPT code 65XX0 should be valued based on a direct work RVU crosswalk

to CPT code 67220 with times as supported by the survey. **The RUC recommends a work RVU of 6.20 for CPT code 65XX0.**

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 Subcommittee clarified that the equipment formula for EL005 *lane, exam (oph)* is based on the total time for post-operative visits that require dilation; while EL006 *lane, screening (oph)*, is based on the total time for post-op visits that do not require a dilated exam. Further, the PE Subcommittee noted, and the RUC agreed, that data indicates the legacy code 65820 was reported with cataract surgery over 90% of the time (CPT codes 66984, 66982, or 66991) and confirmed that the surveyed codes would be subject to the MPPR if performed with the cataract codes. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

Work Neutrality

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

Alcohol & Substance Abuse Assessment (Tab 6)

Trent Emerick, MD (ASRA), Carlo Milani, MD (AAPM&R), Gregory Polston, MD (AAPM), Richard Rosenquist, MD (ASA), Elisabeth Volpert, DNP (ANA), Graham Wagner, MD (IPSIS)

In October 2017, code G0396 was identified on the CMS/Other source codes screen with Medicare utilization of 30,000 or more. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially change "screening" in 99408 and 99409 with "assessment" to mirror G0396. At the February 2018 CPT meeting, the CPT Editorial Panel postponed the coding change application (CCA) until time uncertain. At the time, the rationale for postponement was that the service described in the application did not meet the general criteria for Category I because the proposed service is not unique or well defined and does not describe a service that is clearly identified and distinguished from existing services already described by other CPT codes. Further, the relevant specialty societies were to submit a new CCA to address the differences between assessment and screening services. However, the societies did not provide a new CCA at that time. Without a new CCA, the issue was put back on the Relativity Assessment Workgroup (RAW) agenda for the September 2025 RUC meeting.

In September 2025, the specialty societies indicated they would submit a CCA for the February 2026 CPT Editorial Panel meeting to formally request that "screening" be replaced with "assessment" in the descriptors for CPT codes 99408 and 99409 to eventually replace G0396 and G0397. CPT codes 99408 and 99409 are currently not covered by Medicare (i.e., status "N"). The codes were revised in accordance with the request at the February 2026 CPT Editorial Panel meeting. The 2024 Medicare Claims data for G0396 and G0397 demonstrate that the societies reporting these services have shifted significantly since the original action plan was submitted, suggesting that the service is now predominantly performed by pain medicine societies. Given the code revisions and additional information on the predominant societies, CPT codes 99408 and 99409 were to be surveyed for the April 2026 RUC meeting.

For the April 2026 RUC meeting, the specialty societies submitted a letter stating that the code changes from "screening" to "assessment" are strictly editorial and that the physician work has not changed. After the letter was submitted, a family HCPCS code was identified that was out of sequential order and thus was not considered during the February 2026 CPT Editorial Panel meeting: G2011 *Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit,*

dast), and brief intervention, 5-14 minutes. The specialty societies and RUC agreed that the HCPCS code should be reviewed as part of the code family. After discussion with the RUC, the specialty societies agreed that the reporting specialty had changed, and further, that the February 2026 changes at CPT impacted the typical patient and description of work for CPT codes 99408 and 99409. Given the additional HCPCS code, the specialty societies and RUC agreed that the new code family should be referred to the CPT Editorial Panel prior to survey within the CPT 2028 cycle.

The specialties proposed, and the RUC agreed that the codes G2011, 99408 and 99409 will be referred to the CPT Editorial Panel for revision of the family at the September 2026 CPT Editorial Panel meeting. Specifically, the recommendation is to determine if G2011 should be a Category I CPT code and to revise the descriptor language in parent code 99408 from “abuse” to “misuse”. The code family is expected to be surveyed within the CPT 2028 cycle at the January 2027 RUC meeting. The RUC recommends deletion of HCPCS codes G0396 and G0397.

X. CMS Request/Relativity Assessment Identified Codes

Destruction of Benign Lesion (Tab 7)

Ryan Hick, MD (AADA), Mark Kaufmann, MD (AADA), Howard Rogers, MD (AADA), Susan Walsh, DPM (APMA)

In September 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 17110 as not having been reviewed by the RUC in the last 20 years with 2023 Medicare utilization over 1 million. The RAW requested that the specialty societies submit an action plan for review at the January 2026 meeting. During review of the action plan, the RAW reviewed the August 2025 Office of Inspector General (OIG) study about circumstances when global surgery codes were performed without post-operative visits reported in the global period. The specialty societies indicated, and the RAW agreed the destruction of benign lesion code family (CPT codes 17110 and 17111) be surveyed as 000-day global services for the April 2026 meeting.

At the April 2026 RUC meeting, the RUC and the presenters discussed how the patient population that undergoes destruction of benign lesions is bimodal, with the pediatric population typically receiving treatment for common warts (*verruca vulgaris*) and the adult and elderly population typically receiving treatment for seborrheic keratoses or flat warts (*verruca plana*).

When these codes were last reviewed, in 1997, the codes were surveyed using a clinical vignette for a 23-year-old patient with *verruca plana* (flat warts) on their legs. For this 2026 survey, the societies surveyed the codes using a clinical vignette for a 12-year-old patient with hyperkeratotic warts on their hands and feet, which was approved by the Research Subcommittee. In 1997 there were 35 survey responses and the RUC determined that there was no compelling evidence to increase the value that was determined by refinement.

The specialties noted that the physician work required to treat common warts differs substantially from that of flat warts or seborrheic keratoses. The presenters explained that flat warts are thin and non-hyperkeratotic. Common warts on the hands and feet are hyperkeratotic, requiring more time and effort to remove. The specialties noted that for hyperkeratotic warts, the procedure involves surgically debulking the lesion first before applying cryoablation. When CPT codes 17110 and 17111 are performed on pediatric patients, these patients typically have common warts. Conversely, when these same procedures are performed on older or elderly patients, the patient typically has seborrheic keratoses or flat warts. Although cryotherapy can be used to treat both conditions, the cryotherapy work is not equivalent. Treatment of common warts requires removal of the hyperkeratotic surface,

which acts as an insulator to the liquid nitrogen. Pediatric patients require additional time and effort, increasing procedural intensity in all aspects of the procedure over an adult patient.

The specialties presented compelling evidence that the patient population has changed to typically being pediatric patients with common warts; however, the RUC did not approve compelling evidence.

The RUC observed that 17110 was performed in the traditional Medicare population 3.2 million times and 17111 was performed 150,000 times for traditional Medicare; seborrheic keratosis represents 76 percent and 80 percent of those claims, respectively. The recently released 2024 Medicaid public use data, which does include diagnosis data, alternatively represents approximately 400,000 claims in total. The specialties noted that the survey respondents found both of their vignettes for pediatric patients with hyperkeratotic warts to be typically 98 percent of the time and 96 percent of the time, respectively. The specialties noted that the pediatric population with commercial insurance undergoes these procedures much more commonly. The RUC and the presenters discussed the difference between prevalence data for common warts versus flat warts or seborrheic keratoses and actual treatment data, and the specialties noted the absence of literature directly comparing the number of lesions destroyed between different types of lesions. The RUC did not approve compelling evidence for this code family.

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

The RUC reviewed the survey results from 125 dermatologists and podiatrists and determined a direct work RVU crosswalk to CPT code 64566 *Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming* (work RVU= 0.59, intra-service time= 9.75, total time= 21.75) appropriately accounts for the physician work required to perform this service. The RUC noted that CPT codes 17110 and 64566 typically require similar amount of intra-service time, total time and physician work intensity. The RUC recommends 3 minutes pre-service evaluation time, 2 minutes pre-service positioning time, 2 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time, and 5 minutes immediate post-service time. The surveyed code is typically performed 85 percent of the time with a same-day evaluation and management (E/M) visit in the 2024 Medicare claims data. The RUC ensured that there was no duplicative work or time between the surveyed code and a same-day E/M service.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 69210 *Removal impacted cerumen requiring instrumentation, unilateral* (work RVU = 0.59, intra-service time = 9.75, total time = 16.75) and noted that both services require similar amount of intra-service time and typically the same overall amount of physician work. The RUC also compared the surveyed code to CPT code 11721 *Debridement of nail(s) by any method(s); 6 or more* (work RVU = 0.53, intra-service time = 9.75, total time = 18.75). The RUC determined that a work RVU of 0.59 supported the relativity among similar services. **The RUC recommends a work RVU of 0.59 for CPT code 17110.**

17111 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

The RUC reviewed the survey results from 108 dermatologists and determined a direct work RVU crosswalk to CPT code 11301 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm* (work RVU= 0.88, intra-service time= 14.63, total time= 25.63) appropriately accounts for the physician work required to perform this service. The RUC noted that CPT codes 17111 and 11301 typically require a similar amount of intra-service time, total time and

physician work intensity. The RUC recommends 3 minutes pre-service evaluation time, 2 minutes pre-service positioning time, 2 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 5 minutes immediate post-service time. The surveyed code is typically performed 80 percent of the time with a same-day evaluation and management (E/M) visit in the 2024 Medicare claims data. The RUC ensured that there was no duplicative work or time between the surveyed code and a same-day E/M service.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 11901 *Injection, intralesional; more than 7 lesions* (work RVU= 0.78, intra-service time 12.68, total time= 21.68) and noted that the surveyed code typically requires more intra-service time, total time and more physician work overall. The RUC also compared the surveyed code to CPT code 11306 *Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm* (work RVU= 0.94, intra-service time= 17.55, total time= 28.55) and noted that the reference code typically involves somewhat more time to perform. The RUC determined that a work RVU of 0.88 supported the relativity among similar services. **The RUC recommends a work RVU of 0.88 for CPT code 17111.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made several modifications to the recommendations from the specialty societies. The original proposed direct PE inputs for CPT codes 17110 and 17111 involved sterile procedures, but the specialties agreed to change them to clean procedures. As a result, many of the recommended sterile supplies were replaced with non-sterile alternatives.

Due to modifications made to the supplies resulting in an overall practice expense cost savings, it was determined at the meeting that compelling evidence was not required for the code family.

The PE Subcommittee confirmed that there were no overlapping direct practice expense inputs between the surveyed codes and a same-day E/M service and adjusted several clinical activities to reflect the standard minutes. While the PE Subcommittee acknowledged that the vignette referenced 7 lesions for CPT code 17110, which 98 percent of survey respondents indicated was typical, the Subcommittee noted that the number of lesions could range from 1 to 14. Based on a review of literature and discussion, the Subcommittee recommended that the supplies be adjusted to reflect fewer lesions for CPT code 17110. In general, the recommendations reflect 4 lesions for 17110. The PE Subcommittee also voted to remove the proposed supply SG033 *dressing, 12-7mm (Gelfoam)* as the Subcommittee concurred that these inputs were not typical. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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. The RUC did not accept compelling evidence for this code family.

Maxillofacial Prosthetic Services (Tab 8)

Lionel Candelaria, DDS (ADA), Mark Chambers, DMD (AAMP/ADA), Betsy Davis, DMD (AAMP/ADA), George Grillon, DMD (ADA)

The RUC reviewed the physician work at the April 2026 meeting. However, due to the breadth of clinical staff, supplies, and equipment required to perform these complex services, the PE Subcommittee will continue its review of the direct practice expense inputs, as modified and resubmitted by the specialty society, at the September 2026 meeting. **The RUC will submit work and direct PE recommendations to CMS in October 2026.**

Closed Treatment of Distal Radial Fracture (Tab 9)

William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Jordan Celeste, MD (ACEP), Bryan Graham, DO (ACEP), Amanda Dempsey, MD (ASSH)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 25605 as part of a screen based on 2023 Medicare utilization data of codes with a volume greater than 10,000, that were not surveyed by the specialty society performing over 50% of services, or the top two specialties did not survey the service. In September 2025, the RAW reviewed the action plan and requested that the specialties submit another action plan for January 2026 to determine if this code should be changed to a 000-day global period and resurveyed, since it is reported with Modifier -54 *Surgical Care Only* 90% of the time. The -54 modifier is used when one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, splitting the global period work. In January 2026, the RAW reviewed the action plan for 25605 and agreed with the specialty societies that it be surveyed along with CPT code 25600 as 000-day global services for April 2026.

25600 Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation

The RUC reviewed the survey results from 192 orthopaedic surgeons, hand surgeons and emergency medicine physicians and determined that the 25th percentile work RVU of 0.78 appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes pre-service evaluation time, 1 minute pre-service positioning time, 2 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time, and 5 minutes immediate post-service time. The surveyed code is typically performed 84 percent of the time with a same-day evaluation and management (E/M) visit in the 2024 Medicare claims data. The RUC ensured that there was no duplicative work or time between the surveyed code and a same-day E/M service, noting that the specialty society lowered the pre-service evaluation time to 5 minutes from the time indicated by the survey respondents, which is lower than the standard package time. The RUC also noted that this CPT code is being converted from a 090-day global to a 000-day global period. As the other code in this family (code 25605) is typically performed by emergency medicine in the ER and typically reported with the -54 modifier, both the RUC and the specialties concurred that both codes in the family should be converted to 000-day global periods.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 11104 (work RVU = 0.81, intra-service time = 9.75, total time = 22.75) and noted that both services involve nearly the same intra-service time and the surveyed code involves somewhat more total time. Both services are also typically performed with a same-day E/M visit, and do not include overlap with that same-day E/M, making them appropriate comparator codes for each other. The RUC also compared the surveyed code to CPT code 69200 *Removal foreign body from external auditory canal; without general anesthesia* (work RVU = 0.75, intra-service time = 9.75, total time = 22.75) and noted that the surveyed code involves nearly the same intra-service time, more total time, and is a somewhat more intense/complex service to perform. Both services are also typically performed with a same-day E/M, which does not include overlapping time or work with either procedure code.

The RUC also compared the surveyed code to top key reference code 29075 *Application, cast; elbow to finger (short arm)* (work RVU = 0.75, intra-service time = 14.63, total time = 26.63) and noted that although the reference code has slightly more time and, even though the top key reference code is for a short arm cast and the surveyed code is a splint, the small difference in value would not create a rank order anomaly. CPT code 29075 could be reported for a broader group of injuries, whereas the surveyed code is specifically for a distal radial fracture or epiphyseal separation. In addition to fractures, a short arm cast could also be used for tendon injuries, sprains or may be put on several

weeks after a fracture, after it is already partially healed. The surveyed code, alternatively, is the first mobilization device for an acute fracture. **The RUC recommends a work RVU of 0.78 for CPT code 25600.**

25605 Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation

The RUC reviewed the survey results from 189 orthopaedic surgeons, hand surgeons and emergency medicine physicians and determined that the 25th percentile work RVU of 2.10 appropriately accounts for the physician work required to perform this service. The RUC recommends 15 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 10 minutes immediate post-service time. The surveyed code is typically performed 83 percent of the time with a same-day evaluation and management (E/M) visit in the 2024 Medicare claims data. The RUC ensured that there was no duplicative work or time between the surveyed code and a same-day E/M service. This procedure is typically emergent, performed in the emergency room setting 72 percent of the time, according to 2024 Medicare claims data. This CPT code is being converted from a 090-day global to a 000-day global period.

The presenters noted that this procedure has more pre-service, intra-service and post-service work than the other code in the family. As part of the pre-service, the physician explains the procedure to the patient or the family, reviewing the risks, the complications, and the treatment plan. This procedure also typically involves informed consent. The patient is positioned for the reduction and application of the splint, the extremity is marked, and there is a brief timeout. A hematoma block is also administered, which involves injecting a local anesthetic into the fracture site. This procedure is typically performed using image guidance. The intra-service work involves reducing the fracture by manipulation or other methods. The procedure involves putting on a short arm cast or sugar-tong splint that is placed on both the volar and dorsal aspects, typically around the elbow. The post-service work is getting an X-ray to confirm there is adequate alignment. The physician also assesses the neurovascular status and provides the patient with instructions on elevation, bathing, and signs of neurovascular impairment. The physician typically documents a separate procedure note.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference code 27250 *Closed treatment of hip dislocation, traumatic; without anesthesia* (work RVU = 3.72, intra-service time = 14.63, total time = 52.63) and noted that although both services involve nearly the same intra-service time and very similar total times, the reference code is a more intense procedure to perform. The RUC also compared the surveyed code to MPC code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 2.15, intra-service time = 14.63, total time = 44.63) and noted that both codes involve similar amount of intra-service time, whereas the MPC code which has less total time is somewhat more intense to perform. The RUC concurred that the surveyed code would have appropriate relativity to both reference codes. **The RUC recommends a work RVU of 2.10 for CPT code 25605.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made minor modifications to the recommendations from the specialty societies. The PE Subcommittee adjusted the clinical staff times to eliminate duplication as the surveyed codes are typically reported with a same-day E/M service in the non-facility. The PE Subcommittee confirmed that there were no other overlapping direct PE inputs with the same-day E/M service and accounted for 25605 being

typically emergent. It was clarified that there is typically a separate casting room so equipment items EQ081 *cast cutter* and EQ082 *cast vacuum* were retained for code 25605. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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.

Endoscopic Decompression of Spinal Cord (Tab 10)

William Lavelle, MD (ISASS), Gordon Morewood, MD (ASA), Richard Rosenquist, MD (ASA), Clemens Schirmer, MD (AANS), Karin Swartz, MD (NASS), Graham Wagner, MD (IPSIS)

For January 2026, the Relativity Assessment Workgroup (RAW) reviewed a code that was flagged as Do Not Use to Validate Physician Work in 2016. It is unclear why this service was flagged ten years ago, and therefore, the RAW requested that the specialty develop an action plan. The RAW reviewed the action plan for CPT code 62380. The specialty societies indicated that CPT code 62380 was established in 2016 through a vendor-submitted code change application (CCA). Several specialty societies conducted a survey. Upon review of the data in 2016, the societies deemed the survey results an over-estimation of work because the new procedure was compared to open procedures that had substantially higher intra-service and total time. Consequently, a crosswalk to CPT code 47562 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* was agreed upon by the societies and the RUC to a value that was below the 25th survey percentile and the code was flagged to be reassessed in three years per the typical RUC review cycle for new technology codes. However, in the CY 2017 Final Rule, CMS disagreed with the RUC recommendation and proposed a different lower value, which received many public comments expressing multiple concerns. CMS ultimately assigned contractor pricing, which has remained in place. The RUC agreed with the specialty societies that CPT code 62380 be surveyed for the April 2026 meeting.

62380 Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

The RUC reviewed the survey results from 64 physicians, pain specialists, and anesthesiologists and recommends a work RVU of 11.95 based on the survey 25th percentile, which maintains relativity for this code with other comparable services. The RUC recommends 33 minutes pre-service evaluation time, 15 minutes positioning time, 13 minutes scrub/dress/wait time, 90 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge visit, 2-99213 post-operative office visits, and 236 minutes total time. The specialty societies and RUC agreed that the intra-service time increase from the 2016 survey is justified, given the median experience of the survey respondents, the technical nature, and the actual time needed to successfully perform the procedure.

To perform this procedure, a pristine, non-degenerated bony anatomy is required to allow the procedure to be performed on a disc herniation, and this anatomy is more common in a younger patient population. The patient population for this service is a non-Medicare population; therefore, the specialty societies do not expect a dramatic increase in Medicare utilization. The specialty societies further clarified that one interspace is typical, and it would be atypical to perform this service in an additional interspace.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference service codes 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s)*,

including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar (work RVU = 11.70, 87.75 minutes intra-service time, and 302.75 minutes total time) and 22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level* (work RVU = 14.63, 87.75 minutes intra-service time, and 268.75 minutes total time). The survey respondents that selected the top key reference indicated that the surveyed code was somewhat more or much more intense/complex to perform. Further, these survey respondents indicated that the surveyed code requires more technical skill than the first key reference code. The specialty societies and RUC agreed that the surveyed code recommended value is relative to the first key reference code, and while it is similar, it is more intense/complex to perform, given the loss of tactile opportunity and related anatomical dimension to perform the service endoscopically. Therefore, the surveyed code work RVU is appropriately bracketed by the key reference services.

For additional support, the RUC referenced MPC code 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU = 11.60, 73.13 minutes intra-service time, and 231.13 minutes total time). The reference MPC code is an excellent comparator given that the total time and post-operative work are similar, and the intra-service time of the surveyed code is higher, which supports a slightly higher work RVU. The RUC also referenced CPT code 57260 *Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;* (work RVU = 12.92, 87.75 minutes intra-service time, and 238.75 minutes total time). The CPT reference code and surveyed code have similar intra-service time, total time, and identical post-operative work suggesting that the codes should be valued similarly. **The RUC recommends a work RVU of 11.95 for CPT code 62380.**

Practice Expense

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

XI. Research Subcommittee (Tab 11)

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

- **Review of February 23rd Research Subcommittee Conference Call Reports**

The Research Subcommittee reports from the February 23rd conference call included in Tab 11 agenda materials were approved without modification.

- **Discussion: EHR Time Validation Project Update**

Doctor Weida provided an update about the EHR Time Validation project including the origin of the project, background information, the project scope and its status.

2023/2024 House of Delegates Actions

At the AMA House of Delegates (HoD) Interim meeting in 2023, the American Academy of Family Physicians, American College of Physicians and Florida Medical Association submitted Resolution 821 that called on broader use of “metadata” (eg EHR data) to assess resource use and work relative values. The HoD referred this request to the AMA Board of Trustees for a report at the 2024 Interim meeting. The Board report called for support of the RUC’s continued efforts to identify extant data. At the 2024 Interim meeting, the AMA HoD revised the Board of Trustees

report to state: “That our American Medical Association (AMA) collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee’s study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology.”

Project Initiation

To explore the feasibility of the use of EHR data in the RUC process, the AMA contacted experts who have published on the use of EHR data to estimate procedure time. In September 2025, Nate Apathy, PhD, Assistant Professor of Health Policy & Management at the University of Maryland School of Public Health, provided a presentation to the RUC Research Subcommittee on the use of EHR audit log data to estimate service/procedure time. In December 2025, AMA contracted with the University of Maryland and the University of California San Francisco (UM/UCSF) to conduct a pilot study.

Scope of Project and Current Status

Doctor Weida provided a brief overview of what EHR audit log data is and how the project plans to use these data. He also noted that the RUC formed the EHR Time Validation Technical Panel to provide expertise for this project. The panel and the project researchers held their first meeting on April 13, 2026. The project steps involve:

1. Identifying all CPT codes to which time standards apply (complete)
2. Identifying and extracting all relevant data on the clinical encounters in which these CPT codes were billed at both health systems in calendar year 2025
3. Identifying metrics and usage patterns within the audit log and other EHR usage metadata that represent activities pertinent to operative note time & vital sign entry time
4. Estimating operative note and vital sign time derived from audit log actions and contextual data for all relevant encounters
5. Developing/finalize deliverables, which include a generalizable implementation guide for audit-log-based time estimation, an interim progress report (August 31, 2026), a final report / peer-reviewed manuscript and a presentation to the Research Subcommittee.

CPT Code and Encounter Sampling

Doctor Weida stated that the researchers had explained on the April 13th call with the technical panel that they plan to use the following scope for their analysis:

Operative Note: CPT codes with ≥ 100 total encounters and at least 20 at each site which results in 60 codes with 000-day global periods + 3 codes w/010-day global periods + 12 codes with 090-day global periods. Total: 75 codes & 353,925 encounters (reflects 100% sample)

Staff Vital Signs: CPT codes with ≥ 1000 encounters and at least 500 at each site which results in 68 codes with 3min standard + 56 codes with 5min standard. Total: 124 codes & 592,921 encounters (reflects 10% random sample)

During the Research Subcommittee’s discussion, Subcommittee members and an observer asked clarifying questions about project scope and potential next steps, including using other data sources such as ambient AI usage data for future studies. AMA staff and several technical panel members noted that the initial pilot study is to learn more about how to extract EHR data to potentially validate physician and clinical staff time. They also emphasized that limitations of using EHR data will also be studied. Once the Research Subcommittee and RUC have the opportunity to evaluate the pilot study, the RUC can consider next steps, including whether future pilot studies are warranted.

A question was also asked about how to ensure the accuracy of EHR audit log data. A technical panel member noted that EHR audit log data was originally designed to track access to charts and whether they were improperly accessed. They noted that EHR audit log data is mandated by the HIPAA Security Rule to record all access and activity involving electronic protected health information and therefore, is comprehensive.

The EHR Time Validation Technical Panel will be asked to provide the UM/UCSF researchers with additional guidance on the project, including reviewing audit log descriptions and providing additional context on clinical workflows. A report will be provided to the Research Subcommittee at the September 2026 meeting.

- **Review of Guidelines and Criteria for Crosswalk Codes**

During the RUC's January 2026 new business discussion, a RUC member suggested that the recommended guidelines and criteria for crosswalks be reviewed by the Research Subcommittee, specifically to review the criteria related to the clinical similarity between the surveyed and crosswalk code. The following statement is from the "Instructions for Developing Work RVU Recommendations" document which serves as instructions for specialty society advisors and staff: *"The crosswalk code should have clinical similarities to the survey code."*

Subcommittee members noted that they had recently discussed crosswalk codes, noting that in September 2024, AMA staff provided the Subcommittee with an analysis of all RUC recommendations that were based on a crosswalk. At that time, the Subcommittee concluded that the RUC has an excellent track record of selecting crosswalks that are consistent with the guidelines provided to the specialty societies and no defined requirements for the RUC are indicated. The Subcommittee noted that there were no instances of differing global periods for the five years prior to the April 2024 meeting. In September 2024, the Research Subcommittee agreed that no changes were warranted for the RUC's crosswalk methodology.

At the April 2026 meeting, Subcommittee members noted that the instructions document states "should" and that these are guidelines and not requirements. **The Subcommittee agreed to maintain the crosswalk guidelines included in "Instructions for Developing Work RVU Recommendations" document without modification.**

The RUC approved the Research Subcommittee Report.

XII. Practice Expense Subcommittee (Tab 12)

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

The PE Subcommittee worked extensively on its review of Tab 8 *Maxillofacial Prosthetic Services* which will be completed at the September 2026 meeting. Also at the September 2026 meeting, the PE Subcommittee will review several codes identified by the Relativity Assessment Workgroup as part of its new Qualified Health Care Professional inappropriately included in clinical staff direct PE inputs screen.

There was no New Business discussion.

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (RAW) (Tab 13)

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

Doctor Abouleish highlighted that the RAW reviewed over 30 action plans for approximately 80 codes, primarily for the Qualified Health Care Professional inappropriately included in clinical staff direct PE inputs screen and the new technology/new services screen. Additionally, the RAW will review action plans for 95 codes in September 2026. Doctor Abouleish noted that for the first time the RAW analyzed Medicaid data that was publicly available in February 2026. In September 2026, the RAW will review action plans for services identified using the Medicaid data for CMS/Other source codes, Harvard-valued codes, high volume growth codes and codes reviewed more than 20 years ago with 2024 Medicaid data over 1 million. The RAW will determine if this will be a permanent screen after further examining these services.

Doctor Abouleish indicated to refer to the full Relativity Assessment Workgroup report for additional details.

The RUC approved the Relativity Assessment Workgroup (RAW) Report.

XIV. New/Other Business (Tab 14)

- A RUC member questioned the benefit of pre-facilitation meetings, noting that most concerns were re-adjudicated during the full RUC discussion because recommendations from the pre-facilitation meeting were often not adopted. Several members responded with general support for pre-facilitation. RUC members also provided the following suggestions:
 - When crosswalks are suggested, they should be strongly considered, and societies should be prepared with crosswalks before the RUC meeting.
 - RUC members should ask questions during pre-facilitation so that areas of concern are addressed in advance.
 - AMA staff clarified that if there is consensus in the reviewer comments, specialties are allowed to opt out of pre-facilitation.
- A RUC member requested clarity on who receives the reviewer comments for each RUC tab. AMA staff and the Chair clarified that they are sent directly to the surveying specialty societies and then they are collated and shared with RUC members, RUC alternates, and Practice Expense Subcommittee members.
- A RUC member requested that there be a more formal process when specialty societies raise concerns of identified miscoding. It was stated earlier in the meeting that specialty societies should send these identified items to the appropriate MAC. The member inquired whether the specialty societies could have a specified list of who to contact or if the RUC Relativity Assessment Workgroup (RAW) should pass on those concerns to the appropriate organization and if there could be appropriate follow-up. AMA staff clarified that through the RAW process, when a specialty society has previously identified a potential misuse of a code, that information is formally submitted to CMS in the RUC cover letter. Early in the current administration, a request was made to the AMA related to potential miscoding and all the past identifications of miscoding were collated and re-submitted during that inquiry. CMS has confirmed that the information is shared with the appropriate unit within Health and Human Services (HHS).

The RUC adjourned at 12:10 PM CT on Saturday, April 25, 2026.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE

Research Subcommittee Meeting Report

Friday, April 24th, 9:00 AM Central

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

I. Review of the February 23rd Research Subcommittee Conference Call Reports

The Research Subcommittee reports from the February 23rd conference call included in Tab 11 agenda materials were approved without modification.

II. Discussion: EHR Time Validation Project Update

Doctor Weida provided an update about the EHR Time Validation project including the origin of the project, background information, the project scope and its status.

2023/2024 House of Delegates Actions

At the AMA House of Delegates (HoD) interim meeting in 2023, the American Academy of Family Physicians, American College of Physicians and Florida Medical Association submitted Resolution 821 that called on broader use of “metadata” (eg EHR data) to assess resource use and work relative values. The HoD referred this request to the AMA Board of Trustees for a report at the interim 2024 meeting. The Board Report called for support of the RUC’s continued efforts to identify extant data. At the interim 2024 meeting, the AMA HoD revised the Board of Trustees report to: “That our American Medical Association (AMA) collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee’s study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology.”

Project Initiation

To explore the feasibility of the use of EHR data in the RUC process, the AMA contacted experts who have published on the use of EHR data to estimate procedure time. In September 2025, Nate Apathy, PhD, Assistant Professor of Health Policy & Management at the University of Maryland School of Public Health, provided a presentation to the RUC Research Subcommittee on the use of EHR audit log data to estimate service/procedure time. In December 2025, AMA contracted with University of Maryland and the University of California San Francisco to conduct a pilot study.

Scope of Project and Current Status

Doctor Weida provided a brief overview of what EHR audit log data is and how the project plans to use these data. He also noted that the RUC formed the EHR Time Validation Technical panel to provide expertise for this project. The panel and the project researchers had their first meeting on April 13th. The project steps involve:

1. Identifying all CPT codes to which time standards apply (complete)
2. Identifying and extracting all relevant data on the clinical encounters in which these CPT codes were billed at both health systems in calendar year 2025
3. Identify metrics and usage patterns within the audit log and other EHR usage metadata that represent activities pertinent to operative note time & vital sign entry time
4. Estimate operative note and vital sign time derived from audit log actions and contextual data for all relevant encounters

5. Develop/finalize deliverables, which include a generalizable implementation guide for audit-log-based time estimation, an interim progress report (August 31, 2026), a final report / peer-reviewed manuscript and a presentation to Research Subcommittee.

CPT Code and Encounter Sampling

Doctor Weida explained that the researchers had explained on the April 13th call with the technical panel that they plan to use the following scope for their analysis:

Operative Note: CPT codes with ≥ 100 total encounters and at least 20 at each site which results in 60 codes w/ 0d global period + 3 codes w/ 10d + 12 codes w/ 90d. Total: 75 codes & 353,925 encounters (reflects 100% sample)

Staff Vital Signs: CPT codes with ≥ 1000 encounters and at least 500 at each site which results in 68 codes w/ 3min standard + 56 codes w/ 5min standard. Total: 124 codes & 592,921 encounters (reflects 10% random sample)

During the Research Subcommittee's discussion, Subcommittee members and an observer asked clarifying questions about project scope and potential next steps, including using other data sources such as ambient AI usage data for future studies. AMA staff and several technical panel members noted that the initial pilot study is to learn more about how to extract EHR data to potentially validate physician and clinical staff time. They also emphasized that limitations of using EHR data will also be studied. Once the Research Subcommittee and RUC have the opportunity to evaluate the pilot study, the RUC can consider next steps, including whether future pilot studies are warranted at that time.

A question was also asked about how to ensure the accuracy of the accuracy of EHR audit log data. A technical panel member noted that EHR audit log data was originally designed to track access to charts and whether they were improperly accessed. They noted that EHR audit log data is mandated by the HIPAA Security Rule to record all access and activity involving electronic protected health information and therefore, is comprehensive.

The EHR Time Validation Technical Panel will be asked to provide the UM/UCSF researchers with additional guidance on the project, including reviewing audit log descriptions and providing additional context on clinical workflows. A report will be provided next to the Research Subcommittee at the September meeting.

III. Review of Guidelines and Criteria for Crosswalk Codes

During the RUC's January 2026 new business discussion, a RUC member suggested that the recommended guidelines and criteria for crosswalks be reviewed by the Research Subcommittee to review the criteria related to the clinical similarity between the surveyed and crosswalk code. The following excerpt is from the "Instructions for Developing Work RVU Recommendations" word document which serves as instructions for specialty society advisors and staff includes a bullet that states: *"The crosswalk code should have clinical similarities to the survey code."*

Subcommittee members noted that they had recently discussed crosswalk codes, noting that in September 2024, AMA staff provided the Subcommittee with an analysis of all RUC recommendations that were based on a crosswalk. At that time, the Subcommittee concluded that the RUC has an excellent track record of selecting crosswalks that are consistent with the guidelines provided to the specialty societies and no defined requirements for the RUC are indicated. The Subcommittee noted that there were no instances of differing globals for the 5 years prior to the April 2024 meeting. In September 2024, the Research Subcommittee agreed that no changes were warranted for the RUC's crosswalk methodology.

At the April 2026 meeting, Subcommittee members noted that the bullet in question states "should" and that these are guidelines and not requirements. **The Subcommittee agreed to maintain the crosswalk guidelines included in "Instructions for Developing Work RVU Recommendations" word document without modification.**



Research Subcommittee

Friday, April 24, 2026

9-10am CT

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.
- **The use of recording devices** by any attendee including RUC and HCPAC members, RUC and HCPAC alternates, RUC advisors, specialty society staff and all observers **is strictly prohibited**.
- **The use of recording devices, including annotation plug-ins, by committee and audience members is strictly prohibited.**
- The AMA will record all RUC meetings for reference materials and will be the only recording of RUC meetings allowed.
- 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.
- The 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](#)

CPT Editorial Panel

- Timothy Swan, MD – CPT Panel Member

Centers for Medicare & Medicaid Services

- Mitali Dayal, MSPH – Acting Deputy Director, Hospital and Ambulatory Policy Group
- Stefanie Fischell, MD – Medical Officer
- Edith Hambrick, MD – Medical Officer

Centers for Medicare & Medicaid Services

(attending virtually)

- Perry Alexion, MD
- Lindsey Baldwin, MA
- Morgan Kitzmiller, MHA
- Sarah Leipnik
- Ann Marshall, MSPH
- Mikayla Murphy, MPH
- Maya Peterson, MSN, RN

Contractor Medical Director

- Janet Lawrence, MD

Medicare Payment Advisory Commission (MedPAC)

- Brian O'Donnell, MPP
- Rachel Burton, MPP (*attending virtually*)
- Geoff Gerhardt, MPP (*attending virtually*)

U.S. Government Accountability Office (GAO)

(attending virtually)

- Greg Giusto, MPH – Assistant Director, Health Care Issues
- Pamela (Mela) Brown, MSc – Senior Analyst
- Caylin Rathburn-Smith, MSW, MPH – Senior Analyst

Research Subcommittee Members (2025-2027)

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

AMA EHR Time Validation Project Update



2023/2024 House of Delegates Actions

- At the AMA House of Delegates (HoD) interim meeting in 2023, the American Academy of Family Physicians, American College of Physicians and Florida Medical Association submitted Resolution 821 that called on broader use of “metadata” (eg EHR data) to assess resource use and work relative values.
- The HoD referred this request to the AMA Board of Trustees for a report at the interim 2024 meeting. The Board Report called for support of the RUC’s continued efforts to identify extant data.
- At the interim 2024 meeting, the AMA HoD revised the Board of Trustees report to: “That our American Medical Association (AMA) collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee’s study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology.”

Project Initiation

- To explore the feasibility of the use of EHR data in the RUC process, the AMA contacted experts who have published on the use of EHR data to estimate procedure time.
- In September 2025, Nate Apathy, PhD, Assistant Professor of Health Policy & Management at the University of Maryland School of Public Health, provided a presentation to the RUC Research Subcommittee on the use of EHR audit log data to estimate service/procedure time.
- In December 2025, AMA contracted with University of Maryland and the University of California San Francisco to conduct a pilot study.

What is EHR Audit Log Data?

- A record of activity inside the EHR; it is linked to EHR user, the patient, and has time-stamp data.
- It includes general data on who accessed which patient record at what time and actions were taken (e.g., view, modify, delete).
- It is acknowledged that audit log data does not capture the clinical activities that occur outside of the EHR. One of the goals of this pilot study is to better understand the limitations.

What does the audit log actually look like?

id	visit_id	access_time	user_id	workstation_id	access_action	metric_id	metric_name	metric_desc	metric_group	event_action_type
105	103	3/15/2025 10:20:20	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20607	Storyboard viewed	AC_STORYLINE_VIEWED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
106	103	3/15/2025 10:20:20	GgiTE2kR7vxlv	gYuaVsfxmenFVm€	QUERY	72026	Care Everywhere outside data auto-requested	CE_CHART_OVERVIEW_AUTO_RQST	EVENT AREA - PATIENT CLINICAL INFO	VIEW
107	103	3/15/2025 10:20:21	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20620	Visit Navigator template loaded	AC_VISIT_NAVIGATOR	EVENT AREA - PATIENT CLINICAL INFO	VIEW
108	103	3/15/2025 10:20:22	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20620	Visit Navigator template loaded	AC_VISIT_NAVIGATOR	EVENT AREA - PATIENT CLINICAL INFO	VIEW
109	103	3/15/2025 10:20:22	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17338	OurPractice Advisories displayed	MR_BPA_DISPLAYED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
110	103	3/15/2025 10:20:22	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17126	Allergies activity accessed	MR_ALLERGIES	EVENT AREA - PROBLEMS	VIEW
111	103	3/15/2025 10:20:24	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
112	103	3/15/2025 10:20:27	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
113	103	3/15/2025 10:20:27	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
114	103	3/15/2025 10:20:27	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
115	103	3/15/2025 10:20:27	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
116	103	3/15/2025 10:20:27	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
117	103	3/15/2025 10:20:40	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17259	Patient SnapShot viewed	MR_SNAPSHOT_VIEWED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
118	103	3/15/2025 10:21:22	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17158	Visit diagnoses viewed	VISIT_DIAGNOSES_VIEW	EVENT AREA - PROBLEMS	VIEW
119	103	3/15/2025 10:21:29	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	60010	Pend clinical note	UCNNOTE_PEND	EVENT AREA - CLINICAL NOTES	MODIFY
120	103	3/15/2025 10:22:59	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	60010	Pend clinical note	UCNNOTE_PEND	EVENT AREA - CLINICAL NOTES	MODIFY
121	103	3/15/2025 10:24:30	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17250	Problem List accessed	MR_PROBLEM_LIST_ACCESS	EVENT AREA - PROBLEMS	VIEW
122	103	3/15/2025 10:24:41	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	49003	Visit diagnoses modified	VISIT_DIAGNOSES	EVENT AREA - PROBLEMS	MODIFY
123	103	3/15/2025 10:24:42	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17338	OurPractice Advisories displayed	MR_BPA_DISPLAYED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
124	103	3/15/2025 10:26:45	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
125	103	3/15/2025 10:26:59	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
126	103	3/15/2025 10:27:14	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	60010	Pend clinical note	UCNNOTE_PEND	EVENT AREA - CLINICAL NOTES	MODIFY
127	103	3/15/2025 10:27:15	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17108	Order list changed	MR_ENC_ORDERS	EVENT AREA - ORDERS	MODIFY
128	103	3/15/2025 10:27:16	GgiTE2kR7vxlv	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
129	103	3/15/2025 10:32:57	LCKRkrysbBBv' gYuaVsfxmenFVm€	QUERY		14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT
130	103	3/15/2025 11:14:42	LCKRkrysbBBv' gYuaVsfxmenFVm€	QUERY		14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT
131	103	3/15/2025 11:20:41	LCKRkrysbBBv' gYuaVsfxmenFVm€	QUERY		14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT
132	103	3/15/2025 11:32:57	LCKRkrysbBBv' gYuaVsfxmenFVm€	QUERY		14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT

Credit: Penn Observer Repository (<https://observer.med.upenn.edu>), Epic ACCESS_LOG

Scope of Project and Approach

- The aim of the project is to assess the feasibility of using EHR audit logs & other EHR usage metadata sources to estimate three time standards across two domains:
 - Physician operative notes (5 minutes)
 - Clinical staff time obtaining vital signs (Level 1, 3 minutes; Level 2, 5 minutes).

Vital Signs in the RUC Database

MENU

AMA

RUC Database



Q

99214

+

ADVANCED SEARCH



General Information

RVU History

Vignette/Service

RUC Rationale

RUC Survey Data

Physician Time

Claims Data

Billed Together

PE Inputs

CLINICAL ACTIVITIES DIRECT INPUT-DETAILED

SERVICE PERIOD	CLINICAL ACTIVITY CODE	CLINICAL ACTIVITY DESCRIPTION	STAFF LABOR CODE	STAFF DESCRIPTION	COMP PER MINUTE	NON FACILITY MINUTES	FACILITY MINUTES
Service pre	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.54	3	0
Service pre	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.54	5	0
Service pre	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.54	2	0

RUC Standard Post-Time Packages

Detailed Description of Facility Based Post-Service Time Packages (Minutes)						
	7A Local Anesthesia/ Straightforward Procedure	7B Local Anesthesia/ Complex Procedure	8A IV Sedation/ Straightforward Procedure	8B IV Sedation/ Complex Procedure	9A General Anesthesia or Complex Regional Block/ Straightforward Procedure	9B General Anesthesia or Complex Regional Block/Complex Procedure
Total Post-Service Time	18	21	25	28	30	33
Details:						
Application of Dressing ¹	2	2	2	2	2	2
Transfer of supine patient off table	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Monitor patient recovery/stabilization	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5	5	5

EHR Time Validation Technical Panel

- The RUC also formed the EHR Time Validation Technical panel to provide expertise for this project. The workgroup had its first session with the UM and UCSF researchers on April 13th.

EHR Time Validation Technical Panel Members

Thomas Weida, MD

Gregory DeMeo, DO

Scott Manaker, MD, PhD

John Heiner, MD

M. Douglas Leahy, MD

Christopher Senkowski, MD

Elisabeth Volpert, DNP, APRN, FNP-C

Robert Zwolak, MD

Project Steps

1. Identify all CPT codes to which time standards apply (complete)
2. Identify and extract all relevant data on the clinical encounters in which these CPT codes were billed at the University of Maryland Medical System (UMMS) & UCSF Health in calendar year 2025
3. Identify metrics and usage patterns within the audit log and other EHR usage metadata that represent activities pertinent to operative note time & vital sign entry time

Project Steps

5. Estimate operative note and vital sign time derived from audit log actions and contextual data for all relevant encounters

6. Develop/finalize deliverables:

- Generalizable implementation guide for audit-log-based time estimation
- Interim progress report (August 31, 2026)
- Final report / peer-reviewed manuscript
- Presentation to AMA RUC Research Subcommittee

CPT Code and Encounter Sampling

- **Operative Note**
- CPTs with ≥ 100 encounters and at least 20 at each site
 - 60 codes w/ 0d global period + 3 codes w/ 10d + 12 codes w/ 90d
 - Total: 75 codes & 353,925 encounters (reflects 100% sample)
- **Staff Vital Signs**
- CPTs with ≥ 1000 encounters and at least 500 at each site
 - 68 codes w/ 3min standard + 56 codes w/ 5min standard
 - Total: 124 codes & 592,921 encounters (reflects 10% random sample)

What's Next?

- The EHR Time Validation Technical Panel will be asked provide the UM/UCSF researches additional guidance on the project, including reviewing audit log descriptions and providing additional context on clinical workflows.
- A report will next be provided to the Research Subcommittee at the September meeting.



Physicians' powerful ally in patient care

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, Joseph Cleveland, MD, Neal Cohen, MD, David Han, MD (Vice Chair), Peter Hollmann, MD, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, Adam Weinstein, MD, and Timothy Swan, MD (CPT Resource)

I. New Business

At the September 2025 RUC meeting, under new business, a RUC member requested review of CPT codes that have *L052A Audiologist* as clinical staff in the direct practice expense. Audiology has been able to independently bill Medicare since 2008, therefore, should no longer be accounted for in the direct practice expense inputs as clinical staff. At the same time as this review, the direct practice expense should be examined to identify any other qualified health care professionals captured in the clinical labor staff to ensure that time is appropriately counted in the work component. It was further clarified by the PE Subcommittee Chair that under no circumstance can individuals who separately bill Medicare be included under direct practice expense.

In January 2026, the Relativity Assessment Workgroup (RAW) discussed this issue and determined the specialty societies should submit action plans for the services identified with a QHP included in the clinical staff direct PE inputs. These action plans were reviewed at the April 2026 RAW meeting. There were seven codes where the clinical staff type was changed from the QHP to the L037D RN/LPN/MTA or L042A RN/LPN blend. **Eight codes will require survey and detailed PE review at the September 2026 meeting and 14 codes at the January 2027 meeting.**

Practice Expense Recommendations for CPT 2028

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	Adjacent Tissue Transfer	Modifications	
5	Goniotomy	Unamended	
6	Alcohol & Substance Abuse Assessment	No Survey	
7	Destruction of Benign Lesion	Modifications	

Tab	Title	PE Input Changes	Consent Calendar
8	Maxillofacial Prosthetic Services	Modifications <i>Tab to be continued Sept 2026</i>	
9	Closed Treatment of Distal Radial Fracture	Modifications	
10	Endoscopic Decompression of Spinal Cord	Unamended	

Members: Amr Abouleish, MD (Chair), Gregory N. Nicola, MD (Vice Chair), Dale Blasier, MD, Audrey Chun, MD, Alexandra Flamm, MD, Martha Gray, MD, Gregory Harris, MD, Gwenn Jackson, MD, Kevin Kerber, MD, John McAllister, MD, Kyle Richards, MD, James Shoemaker, MD, Clarice Sinn, DO, Michael Sutherland, MD, John Thompson, MD, G. Edward Vates, MD, Richard Weiss, MD, and Timothy Swan, MD (CPT Resource)

I. Review Action Plans

Category III High Volume (0480T)

In April 2025, the Relativity Assessment Workgroup identified CPT code 0480T *Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)* via the Category III codes with 2023 Medicare utilization over 1,000 screen. The Workgroup noted that these services are identified to notify and get feedback from specialty societies whether a Category I code should be created. In September 2025, the Workgroup recommended reviewing an action plan in April 2026, when 2024 Medicare claims data are available. **In April 2026, the Workgroup reviewed the action plan and recommends maintaining and removing 0480T from the screen because the base code 0479T *Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children* has less than 400 Medicare claims in 2024 and this code set should be reviewed once the base code meets the threshold of 1,000 claims.**

2025 OIG Study on Post-operative Visits (17000, 17003, 17004)

Study 2: August 2025 | A-05-20-00027

CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required

This audit examined global surgeries without any reported postoperative visits, that were not covered by the congressionally mandated audit. It assessed whether the medical record indicated there were postoperative visits and whether the global surgery fee valuation was accurate.

This study reviewed 105 medical records for 41 codes. Only three codes had 5 or more medical records examined. These three codes represented over half of the records reviewed (54%).

CPT code	Procedure	# of records in study	Average # of post-operative visits in study	# of post-operative visits determined by the RUC	RUC Review
17000	Destruction of premalignant lesion, first lesion	34	0	1	April 2013
17110	Destruction of benign lesion, up to 14 lesions	14	0	1	April 1997
17004	Destruction of premalignant lesions, 15 or more lesions	9	0	1	April 2013

In January 2026, the Relativity Assessment Workgroup reviewed and discussed the August 2025 OIG study when global surgery codes were performed without post-operative visits reported in the global period. The Workgroup discussed the destruction of premalignant lesion codes 17000 and 17004 identified via the OIG study. The Workgroup questioned if the destruction of premalignant lesion codes are part of the same family as the destruction of benign lesion codes. The specialty society indicated that these services are not the same family and as there is a distinct difference in patient population, patient intensity is not based on neoplastic risk and rank order issues would not apply because the services are distinct and unrelated. The Workgroup recommended that the specialty societies submit an action plan for CPT codes 17000, 17003 and 17004 to the Relativity Assessment Workgroup in April 2026 on how to address these services.

In April 2026, the Workgroup reviewed the specialty societies' action plan. The Workgroup understands that the specialty society requests that codes 17000, 17003 and 17004 need to be revised to more accurately reflect current clinical practice and physician work before proceeding to survey the code family to allow for accurate reporting and description of physician work for differing types of premalignant processes, such as hypertrophic actinic keratoses. Additionally, the specialty society will address the global period to reflect 000-day for survey. **The Workgroup recommends CPT codes 17000, 17003 and 17004 be referred to CPT for revision.**

RUC Flag (96202, 96203)

In April 2021, the RUC reviewed Caregiver Behavior Management Training codes 96202 and 96203. The RUC recommended that the Relativity Assessment Workgroup review these services in three years (Sept 2024) to review whether the assumption of a median group size of 6 patients remains appropriate. CPT codes 96202 and 96203 were assigned a “bundled” status in 2023. They became status A (active) for 2024. The Workgroup deferred the action plan until April 2026 meeting after the 2024 Medicare data was available.

In April 2026, the Workgroup reviewed the action plan in which the specialty societies confirmed that the typical number of patients per session is 6. The Workgroup agreed with the specialty societies to maintain and remove codes 96202 and 96203 from further examination.

Qualified Health Care Professionals Inappropriately Included in Clinical Staff Direct PE Inputs

At the September 2025 RUC meeting, under new business, a RUC member requested review of CPT codes that have *L052A Audiologist* as clinical staff in the direct practice expense. Audiology has been able to independently bill Medicare since 2008, therefore, should no longer be accounted for in the direct practice expense inputs as clinical staff. At the same time as this review, the direct practice expense should be examined to identify any other qualified health care professionals captured in the clinical labor staff to ensure that time is appropriately counted in the work component. It was further clarified by the PE Subcommittee Chair that under no circumstance can individuals who separately bill Medicare be included under direct practice expense.

In January 2026, the Relativity Assessment Workgroup discussed this issue and determined the specialty societies should submit action plans for the 26 services identified with a QHP included in the clinical staff direct PE inputs. The action plans should address if the services 1) need to be surveyed for work and direct practice expenses reviewed 2) only direct practice expense reviewed, or 3) the clinical staff type be changed.

In April 2026, the Workgroup reviewed the action plans and recommends the following:

Clinical Staff Labor Code	Clinical Staff Labor Description	CPT Code	Recommendation
L052A	Audiologist	92512	Change to L037D RN/LPN/MTA blend
L052A	Audiologist	92516	Change to L037D RN/LPN/MTA blend
L052A	Audiologist	92547	Review PE inputs to remove audiologist (L052A) for September 2026.
L052A	Audiologist	92565	Survey work and review PE September 2026.
L052A	Audiologist	92575	Refer to CPT for deletion - September 2026.
L052A	Audiologist	92577	Survey work and review PE September 2026.
L052A	Audiologist	92596	Survey work and review PE September 2026.
L052A	Audiologist	92552	Survey January 2027. Add 92557 as part of the family.
L052A	Audiologist	92553	Survey January 2027. Add 92557 as part of the family.
L052A	Audiologist	92555	Survey January 2027. Add 92557 as part of the family.
L052A	Audiologist	92556	Survey January 2027. Add 92557 as part of the family.
L052A	Audiologist	92571	Survey September 2026.
L052A	Audiologist	92572	Survey September 2026.
L052A	Audiologist	92576	Survey September 2026.
L052A	Audiologist	92582	Survey January 2027. Add 92579 as part of the family.
L052A	Audiologist	92583	Survey January 2027. Add 92579 as part of the family.
L053A	RN/Speech Pathologist	92612	Survey for January 2027. Add 92613 as part of the family.
L053A	RN/Speech Pathologist	92614	Survey for January 2027. Add 92615 as part of the family.
L053A	RN/Speech Pathologist	92616	Survey for January 2027. Add 92617 as part of the family.
L055A	Speech Pathologist	92520	Survey September 2026.
L045C	CORF socialworker/ psychologist	G0409	Request that CMS remove QHP from the clinical staff direct practice expense inputs and move the PE RVUs to work or contractor price this service.

Clinical Staff Labor Code	Clinical Staff Labor Description	CPT Code	Recommendation
L047D	RN/Registered Dietician	95249	Change to L042A RN/LPN . A CCA has been submitted for the September 2026 CPT meeting to revise these services and it is expected that the RUC will review at the January 2027 RUC meeting.
L047D	RN/Registered Dietician	95250	Change to L042A RN/LPN . A CCA has been submitted for the September 2026 CPT meeting to revise these services and it is expected that the RUC will review at the January 2027 RUC meeting.
L047D	RN/Registered Dietician	98960	Change to L042A RN/LPN . Note: these are bundled services with no Medicare utilization.
L047D	RN/Registered Dietician	98961	Change to L042A RN/LPN . Note: these are bundled services with no Medicare utilization.
L047D	RN/Registered Dietician	98962	Change to L042A RN/LPN . Note: these are bundled services with no Medicare utilization.

New Technology/New Services Review

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 2022 codes that were flagged at the April 2020, October 2020, and January 2021 RUC meetings, with three years of available Medicare claims data (2022, 2023 and 2024).

The Workgroup reviewed the action plans and recommends the following:

CPT Code	Issue	Workgroup Recommendation
33267 33268 33269	Exclusion of Left Atrial Appendage	Survey for September 2026
33370	Percutaneous Cerebral Embolic Protection	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
33509	Harvest of Upper Extremity Artery, Endoscopic and Open	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
43497	Per-Oral Endoscopic Myotomy (POEM)	Survey for September 2026
61736 61737	Intracranial Laser Interstitial Thermal Therapy (LITT)	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

CPT Code	Issue	Workgroup Recommendation
64450 64454 64624 64640	Genicular Injection and RFA	Review in 2 years (April 2028). Notify CMS of possible misreporting based on data from the 2023 Medicare Physician & Other Practitioners - by Provider and Service data. For CPT code 64640 one-third of all claims submitted by only 33 providers and for 64450 40% of all claims were submitted by only 27 providers, including 7% of claims by a single cardiologist.
64451 64625	Radiofrequency Neurotomy Sacroiliac Joint	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
64628 64629	Destruction of Intraosseous Basivertebral Nerve	Review in 2 years (April 2028)
68841	Lacrimal Canaliculus Drug Eluting Implant Insertion	Review in 3 years (April 2029). Noted that this service was identified on the Codes Reported Together 75% or more with 66984 and will be reviewed via this screen at the September 2026 meeting.
77089 77090 77091 77092	Trabecular Bone Score (TBS)	Review in 3 years (April 2029)
91113	Colon Capsule Endoscopy	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
93319	3D Imaging of Cardiac Structures	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
93584 93585 93586 93587 93588	Venography Services	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
93593 93594 93595 93596 93597 93598	Cardiac Catheterization for Congenital Defects	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
94625 94626	Outpatient Pulmonary Rehabilitation Services	Review in 3 years (April 2029). Notify CMS of possible misreporting based on data from the 2023 Medicare Physician & Other Practitioners - by Provider and Service data. For CPT code 94625, 85% of all services were reported by two providers and for CPT code 94626 85% of all services were reported by 10 providers.

CPT Code	Issue	Workgroup Recommendation
99424	Principal Care Management (PCM) & Chronic Care Management (CCM)	Review in 3 years (April 2029)
99425		
99426		
99427		
99437		
99439		
99487		
99489		
99490		
99491		

II. Discussion of Potential New Screen

000-Day Global Period Services Typically Performed Inpatient

In January 2026, during new business, a RUC member suggested that a RAW screen be created to analyze the services with a 000-day global period that are typically performed inpatient to assess if a hospital visit on same date of surgery should be included in the valuation for these services.

AMA examined 000-day services that are typically performed in the inpatient hospital, setting greater than 50% of the time based on 2024 Medicare claims data and reviewed by the RUC after April 2016. In April 2016, the RUC created a 000-day global period survey template that asked if post-operative hospital, critical care, discharge management or office visits are typically performed as well site of service information where the service is typically performed (hospital, ASC or office), when the patient is typically discharged (same day, overnight stay less than 24 hours or overnight stay more than 24 hours) and of those kept overnight what percent typically perform and E/M service later on the same day.

AMA staff identified one service (61736) in which the survey respondents indicated a 99232 *Subsequent hospital inpatient or observation care* service is performed. However, the RUC recommendation removed the hospital visit and added the 20 minutes of hospital time in the immediate post-operative time. CPT code 61736 is performed in the inpatient hospital, setting 93.9% based on 2024 Medicare claims data.

AMA staff identified three services (61624, 61626 and 92941) in which the survey respondents did not indicate a hospital visit was typical but did indicate that the service was performed in the hospital setting more than 50% of the time and the percentage of these patients stayed overnight more than 24 hours. These three services are all typically performed in the inpatient hospital setting based on 2024 Medicare claims data (61624 = 93%, 61626 = 81%, and 92941 = 94.7%).

The Relativity Assessment Workgroup discussed CPT codes 61736, 61624, 61626 and 92941 and determined that the specialty societies should develop action plans for September 2026 to address whether the appropriate hospital visits are currently represented in the global period for these services.

Emergency Medicine 010-090 Day Global Periods

In January 2026, during discussion of the action plan for 25605 *Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation* identified via the Different Performing Specialty from Survey screen, the Relativity Assessment Workgroup questioned why code 25605 is performed by Emergency Medicine physicians more than 50% of the time when it has a 090-day global period and it is questionable if Emergency Medicine physicians would be performing the post-operative visits.

The Workgroup requested AMA staff to run the data for 010 and 090-day global period services performed by Emergency Medicine >50% to review at the April 2026 meeting and determine if these services need further discussion and action plans for the September 2026 RAW meeting.

AMA staff identified 31 codes that have a 010 or 090-day global period with Emergency Medicine performing more than 50% of the time. Of these 31 codes, all but one service is Harvard valued and has not yet met that screen utilization threshold and only 6 codes have more than 1,000 in Medicare utilization in 2024.

The Workgroup reviewed the data and determined that specialty societies should submit action plans for the 6 codes identified (23650, 26770, 27265, 27810, 27818 and 27840) with 2024 Medicare utilization over 1,000.

After review of the action plans, the Workgroup will discuss if these screens should be added to standing RAW screens.

III. 2026 Reiteration of Screens – based on 2024 Medicare Utilization

CMS/Other Source – Medicare Utilization over 20,000

In April 2026, the Workgroup identified five codes that have CMS/Other source and 2024 Medicare utilization over 20,000. **The Workgroup requests that action plans be submitted for codes 77600, G2211 and G2214 at the September 2026 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. The Workgroup recommended that codes G0022 and G0513 be reviewed in 2 years (April 2028).**

Harvard Valued – Medicare utilization over 30,000

In April 2026, the Workgroup identified two Harvard-valued services with 2024 Medicare utilization over 30,000. **The Workgroup requests that action plans be submitted for codes 92283 and 95955 for review by the Relativity Assessment Workgroup in September 2026.**

High Volume Growth

In April 2026, the Workgroup identified 26 codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2019 through 2024. **The Workgroup requests that the specialty societies submit an action plan for codes 36015, 37184, 51715, 64420, 64555, 64561, 64708, 64727, 66030, 75565, 75571, 75572, 75574, 77081, 77285, 77600, 78580, 78814, 92526, 93264, 93622, 96125, 96405, 97026, G0508 and G2011 for September 2026.**

Surveyed by one specialty and now performed by a different specialty

In April 2026, the Workgroup identified two codes where the top two dominant specialties performing services based on 2024 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 code 97610 for September 2026. The Workgroup recommends that 90792 be removed from the list because CMS provider categories do not do not separate psychiatric nurse practitioners from other nurse practitioners.

Category III High Volume

In April 2026, the Workgroup identified nine Category III codes with 2024 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 0101T, 0358T, 0598T, 0607T, 0608T, 0660T, 0671T, 0864T and 0866T for September 2026.**

CPT Assistant Analysis

In April 2026, the Workgroup identified two issues, which the RUC referred to CPT Assistant and an articles were published in 2023. **The Workgroup noted that the CPT Assistant articles addressed the Arthrodesis and Vertebral Corpectomy (22554 & 63081) and Tissue Grafting Procedures (15769) services and therefore further examination is not necessary.**

Work Neutrality (CPT 2024)

In April 2026, the Workgroup identified one issue for codes that were reviewed for CPT 2024 (April 2022, October 2022, and January 2023) that have more than 10% increase in work RVUs from what was projected. **The Workgroup requests action plans for Posterior Nasal Nerve Ablation (30117, 30118, 31242, and 31243) for September 2026.**

Services Reported Together 75% or More

In April 2026, 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 2024 Medicare claims data and/or contained at least one ZZZ global service were removed. **The Workgroup requests action plans for September 2026 to determine if specific code bundling solutions should occur for the following code pairs.**

CPT code 1	CPT Code 2	Reported Together
68841	66984	85%
92537	92540	94%

IV. Medicaid Screens – based on 2024 claims

In February 2026, U.S. Health and Human Services made Medicaid claims data from 2018-2024 publicly available on their open data site <https://opendata.hhs.gov/datasets/medicaid-provider-spending/>. Based on the claims data available, AMA staff were able to run four established screens using the Medicaid data.

Please note that the Medicaid data set does not include 100% of Medicaid claims. Due to CMS' data privacy requirements, certain utilization is excluded from this Medicaid public use dataset. Specifically, if a CPT/HCPCS code is reported less than 11 times by a provider in a calendar month on Medicaid beneficiaries, then that utilization is excluded from the data file.

Medicaid CMS/Other Source

In April 2026, the Workgroup identified six codes that have CMS/Other source and 2024 Medicaid utilization over 20,000. **The Workgroup requests that action plans be submitted for codes 76506, 76827, 77072, 90885, 93303 and 93304 for review by the Relativity Assessment Workgroup in September 2026.**

Medicaid Harvard Valued

In April 2026, the Workgroup identified four Harvard-valued services with 2024 Medicaid utilization over 30,000. **The Workgroup requests that action plans be submitted for codes 36000, 58300, 59025 and 69436 for review by the Relativity Assessment Workgroup in September 2026.**

Medicaid High Volume Growth

In April 2026, the Workgroup identified 11 codes with Medicaid utilization of 10,000 or more that has increased by at least 100% from 2019 through 2024. **The Workgroup requests that the specialty societies submit an action plan for codes 17380, 64615, 90868, 92025, 97151, 97152, 97153, 97154, 97155, 97156, and 97158 for September 2026.**

Medicaid RUC Reviewed > 20 years ago with Medicaid Utilization over 1 million

In April 2026, the Workgroup identified five codes that RUC reviewed more than 20 years ago (prior to 2006) with 2024 Medicaid over 1 million in claims. **The Workgroup requests that the specialty societies submit action plans for codes 76816, 76819, 92015, 92340, 92551 for September 2026.**

After review of the action plans, the RAW will discuss if applying standing RAW screens to Medicaid data should be done regularly.

V. 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.