AMA/Specialty Society RVS Update Committee
The JW Marriott Anaheim Resort, Anaheim, CA
January 15-18, 2025

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in January 2025. Doctor Ezequiel Silva III called the meeting to order on Thursday, January 16, 2025, at 1:00 p.m. PT. The following RUC Members and RUC Alternates were in attendance:

RUC Members:
Ezequiel Silva III, MD
Amr Abouleish, MD
Jennifer Aloff, MD
Margie C. Andreae, MD
Amy Aronsky, DO
Gregory L. Barkley, MD
James Blankenship, MD
Robert Dale Blasier, MD
Audrey Chun, MD
Joseph Cleveland, MD
Gregory DeMeo, DO
Jeffrey P. Edelstein, MD
Alexandra Flamm, MD
Matthew J. Grierson, MD
David Han, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
Omar Hussain, DO
M. Douglas Leahy, MD
Scott Manaker, MD
Bradley Marple, MD
Swati Mehrotra, MD
Gregory Nicola, MD
John Proctor, MD
Richard Rausch, DPT
Kyle Richards, MD
Christopher Senkowski, MD
Lawrence Simon, MD
James Waldorf, MD
Thomas J. Weida, MD
Robert Zipper, MD

RUC Alternates:
Megan Adamson, MD
Anita Arnold, DO
Eileen Brewer, MD
Wayne Causey, MD
Neal Cohen, MD
Neeraj Desai, MD
Daniel Duzan, MD
Leisha Eiten, AuD
Patrick Godbey, MD
Martha Gray, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kevin Kerber, MD
Kristopher Kimmell, MD
Thomas Kintanar, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Lauren Nicola, MD
Michael Perskin, MD
Sanjay Samy, MD
James Shoemaker, MD
Clarice Sinn, DO
Michael Sutherland, MD
Timothy Swan, MD
Thomas Turk, MD
Mark Villa, MD
David Yankura, MD
Robert Zwolak, MD

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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 attendees:
  - Lawrence Simon, MD – CPT Panel Member
  - Timothy Swan, MD – CPT Panel Member
  - Scott Collins, MD – CPT Panel Member

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) attendees:
  - Edith Hambrick, MD – Medical Officer
  - Ryan Howe – Director, Hospital and Ambulatory Policy Group (HAPG)

- Doctor Silva welcomed the following Contractor Medical Director:
  - Janet Lawrence, MD

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- Doctor Silva welcomed the AMA Board of Trustees Chair:
  - Michael Suk, MD, JD, MPH, MBA – Chair

- Doctor Silva recognized the Food and Drug Administration (FDA) attendee:
  - Douglas Kelly, MD – Deputy Center Director for Science, Chief Scientist, Center for Devices & Radiological Health (CDRH)

- Doctor Silva recognized a new RUC member:
  - Alexandra Flamm, MD – American Academy of Dermatology Association (AADA)

- Doctor Silva recognized a new RUC Alternate:
  - Wayne Causey, MD – Society for Vascular Surgery (SVS)

- Doctor Silva recognized dedicated and departing RUC members:
  - David Han, MD (SVS)
  - Omar Hussain, MD (ATS/CHEST)
  - Richard Rausch, DPT, MBA (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.

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  - If specialty society presenters require time to deliberate, please notify the RUC Chair.
  - If RUC advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC chair or AMA staff.

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

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

- Doctor Silva reviewed the business conducted during the Administrative Subcommittee:
  - Reviewed the rotating seat policies and election rules
  - Reviewed and approved the nominations for the Any Other and Internal Medicine rotating seats
  - Noted uncontested seats do not need a vote
  - Rotating seat elections will occur Saturday, January 18, 2025, at 8am PT

- Doctor Silva discussed a resolution at the AMA House of Delegates:
  - November 2023: RUC related Resolution 821 submitted by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP) and Florida Medical Association
  - November 2024: AMA Board of Trustees Report 13 presented to the AMA House of Delegates.
  - The AMA reaffirmed its strong support of the RUC and adopted the report as amended
  - The AMA reaffirmed its support of the RUC and its ability to implement methodological improvements
  - The RUC has a long-standing policy to support the use of extant data that meet criteria and review by the Research Subcommittee.
  - BOT Report 13 language
    - That our American Medical Association 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.
  - RUC leadership and AMA staff will meet with the ACP in late February 2025 to better understand the specific extant data proposal to be submitted by ACP to the Research Subcommittee for consideration at the April 2025 RUC meeting.

- Doctor Silva reviewed items related to Specialty Society Innovation/Investment Transparency:
  - Tab 15 Coronary Atherosclerotic Plaque Assessment
  - Tab 20 Remote Monitoring
    - The American College of Cardiology (ACC) Innovation Program LLC is financially invested in the technology described by Tab 15 and Tab 20.

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        - The ACC Innovation Program is a limited liability corporation (LLC), not controlled by ACC.
    - The RUC's financial disclosure policy applies only to the financial interests held by individuals and their family members and not interests of specialty societies or other healthcare professional organizations. Therefore, the specialty society presenter did not have a direct financial interest to disclose, and the specialty was able to survey and will present on this issue.
    - The specialty was transparent, and the AMA Office of General Counsel reviewed the structure and nature of the relationship between the specialty society and its innovation program. The two entities have separate Board of Trustees and distinct directors, and no overlap in staff or executive leadership. The LLC makes independent investment decisions.

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 recognized the RUC Chair Reappointment:
    - Doctor Silva has been reappointed for a third and final term.
    - Doctor Silva's last term will be March 1, 2025 – February 28, 2027.

- Ms. Smith reviewed the terms of the Subcommittees and Workgroups:
    - The Subcommittee and Workgroup composition are restructured every two years coinciding with the Chair's term.
    - The Subcommittee and Workgroups will be restructured for a new term (March 1, 2025 – February 28, 2027).
    - We sent out a survey to RUC Members, RUC Alternates, RUC Advisors and HCPAC Members to determine which Subcommittees and Workgroups they are interested in serving.
    - Responses are due Friday, January 24, 2025.

- Ms. Smith conveyed the following information regarding the Physician Practice Information (PPI) Survey Update:
    - In 2019, the AMA House of Delegates directed AMA to launch a pilot to test the feasibility of conducting a new PPI Survey effort.
    - Initial interviews (2020/2021) and a pilot (2023) indicated that a survey to collect data directly from financial experts at physician practices and health systems was feasible.
    - The AMA proceeded to contract with Mathematica in 2023 to conduct a significant data collection effort. More than 170 organizations signed a support letter used to assist in response rates. Incentives were provided to respondents.
    - To ensure that physicians were providing input on hours worked in direct patient care, physician hours surveys were also conducted by Mathematica, the AMA, and Medscape.
    - The PPI Survey has concluded with 831 practices/ departments providing usable data. These practices represent 18,086 physicians. Some practices were also able to allocate costs to nurse practitioners and physician assistants.
    - Mathematica also worked with a number of other health care professional organizations to collect data, utilizing the same process and methodology.

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  - Mathematica is finalizing computations and their methodology report. In the coming weeks, the AMA will share all of this information with CMS, the national medical specialty societies, and other health care organizations.

- Ms. Smith reviewed the RUC Database application:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets.
  - Download the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - Current version has 2023 Medicare claims data and 2025 Conversion Factor (CF).

- 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 2026 and 2027 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Apr 1, 2025	Apr 23-26, 2025	Chicago, IL	CPT 2027
Aug 26, 2025	Sep 25-27, 2025	Chicago, IL	CPT 2027
Dec 9, 2025	Jan 14-17, 2026	Los Angeles, CA	CPT 2027

- Ms. Smith announced that the RUC now offers Continuing Medical Education (CME) credits for RUC Meeting Participation:
  - Physicians can earn up to 35.00 AMA *PRA Category 1 Credits*™ and non-physicians can earn a Certificate of Participation.
  - To claim CME credit(s) or Certificate of Participation complete the evaluation provided by AMA Staff at the conclusion of the RUC meeting on or before January 24, 2025.
  - Once you've successfully completed the evaluation, a certificate will be automatically available on February 7, 2025, in the "Transcript" section of your AMA Ed Hub account.

IV. Approval of Minutes from the September 2024 RUC Meeting

The RUC approved the September 2024 RUC meeting minutes as submitted.

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V. CPT Editorial Panel Update

Lawrence M. Simon, MD, MBA, FACS, CPT Editorial Panel Member, provided the following CPT Editorial Panel update on the upcoming February 2025 CPT meeting, where 65 items of business will be discussed.

- Notable Agenda Items
  - 9 Digital medicine related Certified Coding Associates (CCAs)
  - 22 Category III code applications
  - 3 RUC referrals to CPT
  - 67 codes for Category III Sundown
  - 43 codes for CPT code set maintenance

- New CPT Editorial Panel Members
  - Panel Chair: Christopher L. Jagmin, MD
  - Panel Vice Chair: Barbara S. Levy, MD
  - Scott Collins, MD
    - Specialty: Dermatology
    - Panel Seat: National Medical Specialty
  - Rahul Seth, DO
    - Specialty: Medical Oncology
    - Panel Seat: National Medical Specialty

- February 2025 Panel Meeting
  - Transitional Care Management Services (Tab 5):
    - Revise codes 99495, 99496 by reducing the current time frames with patient interactions
  - Computer Assisted Surgical Navigation (Tab 7):
    - Revise code 20985 to include pre-operative or intra-operative image guidance; and delete codes 0054T, 0055T
    - Referred by the RUC to CPT
  - Foot Arthrodesis With Sustained Dynamic Compression (Tab 11):
    - Establish codes 278XX, 287X0, 287X1, 287X2, 287X3, 287X4 for reporting arthrodesis with sustained dynamic compression fixation; and revise arthrodesis codes 27870, 28705, 28715, 28725, 28730, 28735 to specify static fixation
  - Prostate Biopsy Services (Tab 16):
    - Revise codes 55705, 55707-55711, 55713- 55715 to clarify descriptor language for each service
    - Referred by the RUC to CPT
  - Transoral Oropharyngeal Procedures (Tab 18):
    - Establish codes 42XX1, 42XX2 to report transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification
  - Autonomic Function Testing (Tab 30):
    - Establish code 95XX4 for reporting patient preparation, education, and intake for cardiovascular and/or sudomotor autonomic testing; establish codes 95XX5-95XX7 for reporting cardiovascular autonomic function testing with procedure-specific set-up; establish codes 95XX8- 95X10 for reporting cardiovascular autonomic nervous system function; establish codes 95X11-95X16 for reporting autonomic nervous system sudomotor function testing; establish code X430T for

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reporting autonomic function testing with algorithmically enabled diagnostic support; and delete autonomic function testing codes 95921-95924
        - Referred by the RUC to CPT
    - Laser Treatment for Psoriasis (Tab 35):
        - Revise codes 96920, 96921, 96922 by removing limitation of the laser type used
        - Referred by the RUC to CPT
    - Laser Treatment for Psoriasis (Tab 36):
        - Revise codes 96920, 96921, 96922 by removing limitation of the laser type used
    - Unattended Sleep Testing (Tab 40):
        - Establish codes 95X18-95X23, X429T for reporting unattended sleep study services; and delete codes 95800, 95801, 95806
    - Modifier 33 Revision (Tab 63):
        - Request to revise Modifier 33 Preventive Services
    - Telemedicine Services Cleanup (Tab 65):
        - Revise guidelines and parenthetical notes throughout the CPT code set to align with the audio-video and audio-only telemedicine services codes

- CPT Ad Hoc Workgroups: Update - Genomic Sequencing Procedures (GSP) Workgroup:
    - Co-Chairs: Aaron Bossler, MD, Lawrence Simon, MD
        - The Workgroup Chairs are in the process of collecting input from the Molecular Pathology Advisory Group (MPAG), GSP Workgroup, and the Provider Contact Center (PCC) regarding next steps for Carrier and Diagnostic GSP testing in preparation to draft a refined CCA for submission to the Panel.

- CPT Ad Hoc Workgroups: Update - Digital Medicine Coding Committee (DMCC)
    - Co-Chairs: Richard Frank, MD, PhD, Mark Synovec, MD
        - The group met in-person on November 7, 2024 at AMA Headquarters in Chicago.
        - They are continuously working on reviewing Appendix S and the current AI questions in the CCA.
        - They have reviewed all of the CCAs that include an AI component for February 2025 and will be discussing these at their next meeting
    - Next Meetings: The workgroup will continue to meet virtually after the February Panel meeting.

- CPT Ad Hoc Workgroups: Update - Maternity Care Services Workgroup
    - Co-Chairs: Padma Gulur, MD, Timothy L. Swan, MD
        - A stakeholder call was held on November 13, 2024 where high-level coding solutions around the 4 core areas (antepartum care, labor management, delivery, postpartum care) were presented.
        - Extensive feedback was gathered, and the draft proposal was revised.
        - Antepartum and postpartum care have been agreed upon by the workgroup.
        - Labor management and delivery care continue to be worked through, in particular a guideline chart to distinguish the levels of labor management provided.
        - The workgroup will be meeting at the end of January.
        - As of now the workgroup is on task to have a staff generated CCA submitted for the May 2025 CPT Editorial Panel Meeting.

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- CPT Ad Hoc Workgroups: Update - Value Based Care Services Workgroup
    - Co-Chairs: Leo Bronston, DC MAppSc, Samuel Church, MD, Steven Hao, MD
        - This joint CPT/RUC Workgroup was created as a result of the priorities identified at the July 2024 special session of the Panel.
        - This workgroup is being conducted in collaboration with Manatt Health to reach its identified goals.
        - An initial meeting of AMA staff and Manatt was held to provide the co-chairs with the planned process including the identification of 2 phases.
            - Phase One: Review current CPT care management codes.
            - Phase Two: Discuss and propose a plan to address episodes of care bundles.
        - The full workgroup was brought on board including an additional CMS liaison (Douglas Jacobs) with specific expertise in value-based care.
        - On call, a full workgroup call was held to provide the background on the workgroup creation and an overview of Phase 1. As a result of the first call, it was identified that Phase one may not last long and identified work could be part of Phase two
        - Further Phase one work will continue by email and a second workgroup call will be held in February.

- Upcoming CPT Editorial Panel Meetings
    - The next Panel meeting is February 6-8, 2025 – San Jose, California
    - The next application submission deadline is February 10, 2025.

VI. Centers for Medicare & Medicaid Services Update

Ryan Howe, Director of the Hospital and Ambulatory Policy Group (HAPG) provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the CY 2025 Medicare Physician Payment Schedule (MFS) Final Rule.

- Mr. Howe thanked the RUC and noted that he is excited to join the RUC in person for this meeting.
- Mr. Howe addressed the change in federal government leadership taking place in the coming week and expressed that CMS is eager to see in what direction the new leadership takes the agency.
- Mr. Howe provided a high-level overview of the 2025 Medicare Physician Payment Schedule Final Rule including recognition of changes in care and making sure that payment rates and coding used under Medicare adequately addressed those changes in practice to ensure access to the best possible care.
- Mr. Howe acknowledged the CPT and RUC processes.
- Mr. Howe addressed telehealth, noting the impact the pandemic had in accelerating the adoption of telehealth while still working with outmoded statutes. He noted the extended provisional status for telehealth flexibilities. CMS continues to gather information on telehealth to formulate policy and address any new legislation.

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VII. Contractor Medical Director Update

Janet Lawrence, MD, MS, FACP Contractor Medical Director (CMD), National Government Services, provided the CMD update.

- Local Coverage Determinations (LCDs)
  - Artificial Intelligence Enabled CT Scan Based Quantitative Coronary Topography (AIQCT) - In Notice
  - Minimally Invasive Glaucoma Surgery (MIGS)
  - Skin Substitutes – Effective February 12, 2025
  - The Peripheral Nerve Block Contractor Advisory Committee (CAC) will be February 3, 2025
  - Health Equity Advisory and Leadership (HEAL) workgroup – looked at ways to include equity in the LCD development process

- Molecular Diagnostics
  - Technical assessments are being done on proteomics so that LCDs can be written to guide their utilization

- Artificial Intelligence (AI)
  - New administration: therefore, there is an expectation for more activity by federal agencies
  - Medicare Administrative Contractor (MACs) plan to facilitate evidentiary discussions to inform how AI enabled devices are evaluated by our technology assessments.
  - Goal is for multi-MAC Contractor Advisory Committee (CAC) meeting this year (tentative plan). AI WG goal to recruit participation of SMEs to advise best practices.
  - Types of AI:
    - Machine Learning (ML):
      - Identifies patterns and predicts outcomes using large datasets.
    - Deep Learning (DL) Neural Networks:
      - Used for complex tasks like image analysis (e.g., diabetic retinopathy detection).
    - Natural Language Processing (NLP):
      - A form of DL that converts text into structured data for analysis (e.g., chatbots, clinical notes).
    - Generative AI:
      - A subset of DL that generates content and insights based on large datasets (e.g., ChatGPT)
  - Types of Machine Learning (ML) models:
    - Supervised models are given input-output pairs and find the best function to link them
    - Inputs are structured data (lists of numbers)
    - Aim is to add new inputs into the model to produce new outputs (numerical value or a predicted risk category)
    - Glass Box Models
    - Unsupervised models use multiple hierarchical layers of logistic regression to perform complex tasks
    - Used to categorize unlabeled examples of data into groups with shared features
    - Relationship between inputs may be uncertain
    - Black Box Models

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        - Reinforcement learning models interact with an environment through continuous observation and iteration
        - Require re-evaluation over time as the models evolve

- Dental
    - MACs have determined resources for how these procedures will be covered and are standardizing pricing within each MAC
    - Pricing mechanisms have not been standardized among the MACs yet
    - Dental coverage has been expanded to include coverage of beneficiaries with End Stage Renal Disease effective January 1, 2025
    - Dental claims may be submitted using the dental (837D), institutional (837I), or professional 837Pclaim forms and Medicare will accept CDT or CPT/HCPCs codes when billed.

- Telehealth
    - Flexibilities will remain in place through March 31, 2025, due to the Congressional action
        - Medicare beneficiaries can
            - Access telehealth services in any geographic area in the U.S., rather than only those in rural areas
            - Stay in their homes for telehealth visits rather than traveling to a health care facility
            - Certain telehealth visits can be delivered audio-only if someone is unable to use both audio and video
            - Mental health requirements for in-person visits remain on hold
        - An originating site is the location where a patient is located and receives medical services via telehealth
        - Through 3/31/2025
            - Patients can get telehealth wherever they are located
            - No geographic location restrictions
        - After 3/31/2025
            - For non-behavioral telehealth services, there may be originating site requirements and geographic location restrictions
            - For behavioral or mental telehealth services, all patients can continue to get telehealth wherever they are located, with no originating site requirements or geographic location restrictions

- Miscellaneous
    - G2211 usage has been expanded January 1, 2025, to include Evaluation and Management (E/M) services provided on same day as an Annual Wellness Visit (AWV), injection administration, and preventive services
    - These are services that may cause the E/M to be billed with modifier 25 which was previously not allowed for G2211
    - National Government Services (NGS) has created an extensive FAQ on G2211 and our working to update that constantly other contractors have FAQs as well

- Doctor Lawrence addressed questions from attendees:
    - A RUC member inquired about clarification on the multi-MAC workgroup policies related to a Minimally Invasive Glaucoma Surgery (MIGS) Local Coverage

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Determination (LCD) that was effective November 17, 2024 and if that is being revised based on the comments today. Doctor Lawrence clarified that it would continue, however, there are a few additions forthcoming and that while the MAC's work collaboratively, that does not guarantee a simultaneous response.

VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, provided the Washington report focusing on AMA Advocacy on Medicare Physician and Qualified Health Professional (QHP) Payment, the 2025 Medicare Physician Payment Schedule Final Rule, and the 2025 Medicare Shared Savings Program (MSSP) and Quality Payment Program (QPP) Policies.

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

- Medicare Conversion Factor
  - For the fifth straight year, the Medicare conversion factor will decline
    - Physicians and QHPs face a 2.83% cut from $33.2875 to $32.3465.
  - Why?
    - Expiration of temporary 2.93% update at the end of 2024
    - 0% baseline statutory update under the Medicare Access and CHIP Reauthorization Act (MACRA)
    - Budget neutrality adjustment of +0.02%
  - Physician and QHP payments fall further below the rate of inflation.
    - CMS projects that the costs to provide care and run a medical practice as measured by the Medicare Economic Index will increase by 3.5% in 2025.

- AMA and Organized Medicine Advocacy
  - A bipartisan letter (Oct. 2024) to House leadership urging Congress stop the 2.8% cut and provide an inflationary update garnered 233 cosigners.
  - Senate companion letter (Nov. 2024) generated more than 40 bipartisan cosigners.
  - Federation letter (Nov. 2024) in support of H.R. 10073, the Medicare Patient Access and Practice Stabilization Act

- Year-End Short-Term Government Funding Bill

Includes:	ALMOST included:
• Funding for federal government through March 14 • Telehealth flexibilities extension until March 31 • 1.0 Work Geographic Practice Cost Index (GPCI) floor extension until April 1	• Increasing physician and QHP pay by 2.5%, erasing nearly all the 2.8% reduction to the Conversion Factor (CF) • Extending the Alternative Payment Model (APM) bonus at 3.5% for 2025 performance year (up from 1.88% for 2024) • Extending telehealth flexibilities for two years

- AMA: Congress fails patients and physicians
  - "The Continuing Resolution utterly fails to address declining reimbursement rates for Medicare, pushing our health system down a path that will have predictable and deleterious results. For the fifth consecutive year, Congress has adjourned and allowed

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Medicare cuts. What will be the result? Patients struggling to access health care. Physicians closing or selling their private practices while others opt to leave the profession.

- "Congress heads home today leaving in place a 2.83 percent cut for doctors. It did not provide a rational permanent, inflation-based update as the Medicare Payment Advisory Commission recommended. It didn't even offer doctors a Band-Aid in the form of a cut reduction, as the cost of delivering care rises 3.5 percent next year." - Bruce A. Scott, M.D., President, American Medical Association

- Where Do We Go From Here?
  - AMA is working closely with Reps. Greg Murphy, MD (R-NC), Jimmy Panetta (D-CA), Mariannette Miller-Meeks, MD (R-IA), and a few other physician Members of Congress to reintroduce a revamped version of the Medicare Patient Access and Practice Stabilization Act (H.R. 10073 in the 118th Congress) to:
    - Prospectively stop the 2.83% cut from March-December 2025, AND
    - Update physician and QHP pay by 50% of the Medicare Economic Index
  - Update physician and QHP pay by 50% of the Medicare Economic Index
  - Bill would still include the crucial inflationary update that is one of the major concerns facing physician practices.

- Physicians and QHPs Must Keep Up the Pressure on Congress
  - Attend AMA's National Advocacy Conference, February 10-12, 2025
    - Join the inaugural "Fix Medicare Now" event on Feb. 11 at the US Capitol
    - The event will feature speeches from prominent house members urging Congress to pass legislation to reverse the latest round of cuts and to overhaul the Medicare physician payment system
  - Stay engaged in FixMedicareNow.org campaigns
    - Write your members of Congress
    - Share your story about the impact of Medicare pay cuts on your practice and patients
    - Raise awareness using the social media toolkit

- **2025 Medicare Physician Payment Schedule Final Rule**

- Payment Policies
  - CMS continued to delay implementation of the 2017-based Medicare Economic Index (MEI) cost weights, pending the AMA's Physician Practice Information (PPI) Survey.
    - This delay responds to AMA Advocacy to continue to use physician practice cost survey data in determining the MEI cost weights and the criticism by the AMA and national medical state and specialty organizations of the data sources and methodology proposed by CMS.
  - CMS accepted and implemented 91 percent of the RUC recommendations for new/revised CPT codes and codes identified via the RUC's potentially misvalued services process.
    - CMS also accepted and implemented a RUC recommendation to update clinical supply packages.
    - While the CMS proposal for telemedicine will not recognize the new telemedicine office visit codes for Medicare payment, the RUC recommendations for these services are published without revision.

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- Telehealth
    - Congress extended the geographic and originating site waivers, and other flexibilities, through March 31, 2025.
    - The final rule includes policies that improve telehealth access in multiple ways, including:
        - Most importantly, after nearly 5 years of AMA advocacy, CMS has finalized a change to its definition of telecommunications system to now include audio-only services.
        - CMS extended for one year the ability to provide virtual direct supervision and virtual supervision of residents when the resident provides telehealth services.
        - Frequency limits for subsequent hospital and nursing facility telehealth visits were lifted for one more year.
        - Physicians providing telehealth from their homes do not have to report their home addresses to Medicare.
        - In a setback for medicine, CMS finalized its decision to post the new CPT telemedicine E/M codes and relative values but not adopt them for use in Medicare.
        - CMS acknowledged AMA comments that these codes should not be subject to Medicare's statutory definition of telehealth and thus should be able to be used for Medicare patient services without new legislation being enacted but says that it was not persuaded by them
        - AMA also warned of confusion if other payers and possibly Medicare Advantage plans utilize the new, more precise CPT telemedicine codes but PFS services instead continue to be reported with codes for in-person office visits plus modifiers to designate if they are audio-only, audio-video, and/or delivered to the patient's home. CMS states that it will develop educational materials to assist in correct coding.
        - CMS adopted the new CPT code 98016 describing a brief communication technology-based service, which was previously reported with HCPCS code G2012.

- Advanced Primary Care Management Services
    - CMS finalized three monthly HCPCS G-codes for providing advanced primary care services to patients.
    - The codes bundle in elements of current Medicare care coordination services but do not have a time-based threshold.
    - Despite the AMA's concerns about the burdensome requirements to bill the Advanced Primary Care Management Services (APCM) codes and recommendation to tier payment based on the capabilities of the practice using the RUC's recommendations for a patient-centered medical home, CMS finalized the infrastructure requirements as proposed. CMS noted that the RUC recommendations for tiering APCM payment based on practice capabilities are inconsistent with CMS' goals to pay physicians who have already transitioned to an advanced primary care delivery model, not those who are in the process of transitioning to this model of care.

- Strategies for Improving Global Surgery Payment Accuracy
    - For 90-day global codes, surgeons should use modifier -54 when they plan to furnish only the surgical procedure portion of the global period, including when there is a formal, documented transfer of care as under current CMS policy or an informal, non-documented but expected transfer of care.

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  - Appending this modifier will reduce the payment rate to reflect that the surgeon is not providing the post-operative portion of the service.
  - The AMA raised concerns that applying a payment reduction to surgical codes billed using modifier -54 and the multiple procedure payment reduction (MPPR) would duplicate the reduction and be inappropriate because the MPPR already reduces the payment for the second and subsequent services to remove payment for post-operative care. Despite these objections, CMS will apply both payment reductions.

- **2025 Medicare Shared Savings Program (MSSP) and Quality Payment Program (QPP) Policies**

- MSSP Accountable Care Organizations (ACOs)
  - CMS will hold ACOs harmless from significant, anomalous, and highly suspect (SAHS) billing activity, such as improper payments for urinary catheters in 2023, which the AMA strongly supported. We urged CMS to apply the same hold harmless policies in MIPS.
  - CMS established a new "prepaid shared savings" option in which eligible ACOs with a history of shared savings can be approved for advance shared savings they can use to invest in enhanced care services, care coordination, or infrastructure.
  - In response to AMA advocacy, CMS granted ACOs more flexibility for reporting quality measures.

- Merit-based Incentive Payment System (MIPS)
  - The AMA strongly supported, and CMS finalized its proposal to maintain the MIPS performance threshold to avoid a penalty at 75 points.
  - After years of AMA flagging our concerns with CMS' policy of capping "topped out" quality measures at 7 points, CMS finalized its proposal to remove the cap for certain measures and implemented a flat benchmark for scoring. The AMA urged CMS to expand the policy to all topped out measures.
  - CMS modified the cost measure scoring methodology beginning with the 2024 performance period with the aim of increasing the scores of physicians and QHPs who deliver care at an average cost. The AMA has raised concerns with the cost measures, which are generally scored lower than other MIPS measures, as not all physicians and QHPs are scored on cost measures.
  - CMS simplified reporting in the Improvement Activities category.

- MIPS Value Pathways (MVPs)
  - CMS finalized six new MVPs for 2025 around the following topics without major changes: Complete Ophthalmologic Care, Dermatological Care, Gastroenterology Care, Optimal Care for Patients with Urologic Conditions, Pulmonology Care, and Surgical Care.
  - Although CMS did not respond to our recommendations, the AMA has developed an alternative MVP framework, which we call the Condition-Stratified MVP Framework, to address many of the pitfalls of the current CMS approach to MVPs.
    - This alternative framework categorizes quality and cost measures into condition-specific subdivisions within a broader MVP.
    - Physicians who specialize in treating a particular condition would be able to clearly identify the available measures for that condition and register to be held accountable for those condition specific quality and cost measures within the MVP.

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- CMS and physicians could also more easily identify and remedy gaps in measurement and scoring challenges, such as no or limited condition specific measures or measures without a benchmark.

IX. Relative Value Recommendations for CPT 2026

Hip and Pelvis Arthrodesis Revisions (Tab 4)
Curtis Anderson, MD (OEIS), Michael Booker, MD (ACR), Minhaj Khaja, MD (SIR), Karin Swartz, MD (NASS)

In May 2022, the CPT Editorial Panel created Category III code 0775T for CPT 2023 to report percutaneous sacroiliac (SI) joint arthrodesis using an intra-articular implant(s), such as bone allograft material or synthetic devices. In September 2022, the Panel replaced Category III code 0775T with a new Category I code 27278 *Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device*, which was surveyed for and valued at the January 2023 RUC meeting. CPT code 27278 was flagged for new technology and is expected to be re-reviewed by the RUC in 2027.

CPT code 27279 *Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixation device* was added as a family code to the January 2023 level of interest (LOI) form. However, the specialty societies requested that this code not be re-reviewed with 27278, therefore, the RUC submitted no recommendation for 27279 at the January 2023 RUC meeting.

At the September 2024 CPT Editorial Panel meeting, three separate code change applications (CCAs) were submitted that proposed changes to the guidelines and codes 27278 and 27279. The CPT Editorial Panel combined the CCAs and addressed the matter to further clarify the term "transfixation" through editorial changes to these codes.

In preparation for the January 2025 RUC meeting, the specialty societies delivered two separate letters to the RUC that detail the revisions to each of these codes made by the CPT Editorial Panel and presented a comprehensive timeline outlining the CCAs considered at previous CPT Editorial Panel meetings. In these letters, the specialty societies note that the changes made by CPT to these codes are editorial and request that neither be resurveyed for the January 2025 RUC meeting. The specialty societies requested affirmation by the RUC of the current value for both CPT codes 27278 and 27279, noting that the RUC will have an opportunity to review these codes via the Relativity Assessment Workgroup's new technology screen or as the result of a pending CPT CCA at the February 2025 CPT Editorial Panel meeting which was brought forth independently by the specialty societies. The RUC noted it is well past the time for affirmation of 27279 in terms of when that service was last surveyed in April 2018. The RUC did not vote on affirmation for codes 27278 and 27279 and instead agreed to submit no recommendation.

The RUC submits no recommendation regarding CPT codes 27278 and 27279 as they were not re-reviewed or re-surveyed for the January 2025 RUC meeting.

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Thoracic Branch Endograft Services (Tab 5)
Minhaj Khaja, MD (SIR), Matthew Sideman, MD (SVS), Jonathan Thompson, MD (SVS), Prashanth Vallabhajosyula, MD (STS)

Endovascular repair of thoracic aortic aneurysms (TEVAR) received FDA approval in March 2005 following the pivotal trial utilizing the Gore Thoracic Branch Endoprosthesis (TAG) device. This was approximately 5 years after FDA approval of endovascular devices for abdominal aneurysm repair. A family of TEVAR codes was presented to the RUC in April 2005. At that time, TEVAR was typically performed by a team of physicians, including vascular surgeons, cardiothoracic surgeons, and interventional radiologists. These codes utilized component coding to account for various providers and portions of the procedure performed. The TEVAR family of codes appeared in the 2006 Medicare Physician Payment Schedule (MFS), and the values have not been reviewed since that time. In May 2022, the FDA approved the use of a thoracic branch endoprosthesis (TBE) during TEVAR procedures. This was the first new type of device to gain FDA approval within the TEVAR code family.

The CPT Editorial Panel approved TEVAR coding changes at the September 2024 CPT meeting. This recommendation includes 2 new codes, 4 revised codes, and 3 code deletions. The new family of codes updates the TEVAR code family to current coding standards as outlined below:

1. Catheter placement is now bundled into the main procedure.
2. Radiologic supervision & interpretation is now bundled into the main procedure.
3. All proximal extensions performed at the time of TEVAR are now bundled into the main procedure.
4. A new code has been created for the distinct work required for a TBE, which includes all the work of a TEVAR.
5. There will no longer be separate codes for extra-anatomic bypass surgery performed in conjunction with TEVAR.

The new 6-code family for TEVAR represents a complex set of operations that now include pre-planning, all radiologic supervision and interpretation, all routine catheterization, and all currently placed extensions at the initial time of TEVAR. This updated code family more accurately describes the current practice of TEVAR and conforms with current concepts in CPT code creation and valuation. Additionally, the deletion of bypass codes at the time of TEVAR will help simplify coding by reducing the number of codes that describe the same work, which can lead to confusion and improper coding. The specialty societies surveying this code family requested modification to the 090-day survey tool to include language regarding pre-planning time, changes that were similar to those made to the endovascular aneurysm repair (EVAR) survey tool for the January 2017 RUC meeting and the Iliac Branched Endograft survey tool for the January 2019 RUC meeting. With these modifications, the survey tool provides survey respondents with the opportunity to account for this pre-planning time, which is extensive and often occurs more than 24 hours before the procedure due to the surgical complexity. The 2 new codes and 4 revised codes in the TEVAR family were all surveyed for the January 2025 RUC meeting.

33380 ***Endovascular repair of thoracic aorta, including pre-procedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation; by deployment of an aorto-aortic tube endograft covering the left subclavian artery and all aortic tube endograft extension(s) proximally in the aortic arch and ascending aorta and distally to the celiac artery, when performed***
The RUC reviewed survey results from 64 vascular surgeons, cardiothoracic surgeons, and interventional radiologists and recommends the 25th percentile work RVU of 30.00, which accounts

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for the physician work required to perform this service. The RUC recommends 100 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 1-99291, 1-99233, 1-99232, 1-99238, 1-99214 and 1-99213 visit, which equals 546 minutes of total time.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure*. The selected time package was modified to more accurately reflect pre-service planning collected in the modified survey tool to more accurately reflect pre-service time involved with this service. The specialty society requests 100 minutes of pre-service evaluation time which is consistent with the median survey results and 60 minutes above the standard pre-service package time of 40 minutes. The additional pre-service evaluation time includes 40 minutes for pre-service evaluation plus 60 minutes for pre-planning, which should be bundled in the main procedure and cannot be reported separately per CMS policy. For this service, the pre-planning time review includes confirming the suitability of the anatomy for TEVAR. To do this, a large number of measurements are required, including aortic diameters throughout the aorta, outer and inner curve lengths, center-line lengths from arch vessels to the celiac, subclavian diameters, distance from the left subclavian to the vertebral artery, and diameters of the access vessels (common femoral, external iliac, and common iliac arteries). Additionally, the surgeon assesses the perceived quality of the aorta, particularly in the seal zones, and the tortuosity of the aorta. During this planning, the surgeon reviews all available endograft sizes from several vendors and develops a specific operative plan and device selection that will successfully treat the pathology at hand. This may require ordering specific devices and components which are not readily available at the surgeon's institution. This service is provided after evaluation in the office but more than 24 hours before the procedure, however, is not separately reported. The RUC agreed with the other pre-service time components to complete the necessary positioning and scrub/dress/wait time. Further, the RUC agreed with post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*, hospital visits, and the post-operative visits.

The specialty society requests 15 minutes of pre-service positioning time which is consistent with the median survey results and 12 minutes above the standard pre-service package time of 3 minutes. The additional pre-service position time accounts for positioning the imaging equipment and operating room equipment to minimize conflicts between equipment and patients during the surgery, appropriately positioning the patient with arms tucked as indicated, and confirming that all EKG leads and IV, Foley and arterial catheter lines are clear from the areas to be imaged during the procedure. This extra time is 5 minutes less than the positioning time included with abdominal aortic aneurysm endovascular repair codes (34701-34708).

The specialty society selected post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. Regarding post-operative hospital care, the specialty societies provided a detailed rationale to support their recommendation. Among survey respondents, there was a uniform consensus that ICU-level care is provided by the surgeon during the post-operative period. Patients who have undergone thoracic endografting have always been transferred to the ICU immediately post-operatively, but any critical work was generally performed by dedicated critical care personnel. Over time, endovascular repair for thoracic pathology has increased from simple aneurysms to now including dissections, penetrating aortic ulcers, and even traumatic ruptures. A wider range of patients with a wider complexity of overall health are being treated with these minimally invasive approaches and longer segments of the aorta are now routinely covered, increasing the risk of spinal cord ischemia. Spinal cord ischemia, though uncommon, is a devastating potential complication for any thoracic aortic work, which has always been and is still best understood and managed by the operating surgeon. Thus, it is typical that prophylactic lumbar drains are still used for elective TEVAR cases, as they were required in the primary trial for the TBE device. Lumbar drains are

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placed by neurosurgery or anesthesiology before surgery in the operating room, and the ongoing measuring of perfusion to the spinal cord, as well as drain management, is managed by the operating surgeon.

Regarding post-operative office visits, the specialty societies noted that survey respondents indicated that while the number of TEVAR post-operative visits has not changed, the visits are now more complex. The first visit, which typically occurs 1-2 weeks following hospital discharge, is a level 3 post-op office visit (99213), wherein incisions are checked, wound care is provided, and a neurovascular assessment is performed. The second visit, which typically occurs 4-6 weeks following hospital discharge, is a level 4 post-op office visit (99214). Much of this time is spent by the operating surgeon reviewing the postoperative CT scan, which is from the aortic arch to the femoral vessels with fine cuts. Three-dimensional software is utilized to evaluate possible endoleaks or other endograft complications, and clinical decisions are made regarding the need for repeat surgical intervention. This work is independent and distinct from any radiologist's interpretation. Given the increased complexity and treatment length of these visits, more work and time is required for the operating surgeon to review these images and discuss them with the patient compared to 20 years ago when these codes were first valued.

To support the recommended work RVU of 30.00, the RUC compared the surveyed code to top key reference code 34708 *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)* (work RVU = 36.50, 120 minutes intra-service time, 677 minutes total time) and second key reference code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service time, 512 minutes total time). The RUC recognized that the surveyed code is appropriately compared to the two key reference services in terms of intra-service time and total time, as well as relative intensity and complexity. The top key reference service code 34708 has identical intra-service time compared to the surveyed code, but the surveyed code requires less total time and is a less intense procedure for the physician to perform, thus justifying a lesser work RVU. Notably, the two key reference services chosen by survey respondents bracket the 25th percentile surveyed code work RVU and total time.

For additional support, the RUC referenced MPC codes 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts* (work RVU = 39.88, 193 minutes intra-service time, 717 minutes total time) and 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time, 404 minutes total time), noting that code 35301 has identical intra-service time compared to the surveyed code, but requires 142 less minutes in pre-service time and post-operative visits. Together, both MPC codes require a similar measured intensity and complexity for the physician to perform. **The RUC recommends a work RVU of 30.00 for CPT code 33380.**

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33381 ***Endovascular repair of thoracic aorta, including pre-procedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation; by deployment of an aorto-aortic tube endograft covering the left subclavian artery and all aortic tube endograft extension(s) proximally in the aortic arch and ascending aorta and distally to the celiac artery, when performed by deployment of an aorto-aortic tube endograft not involving coverage of the left subclavian artery origin and all endograft extension(s) placed from the level of the left subclavian carotid artery to the celiac artery***
The RUC reviewed survey results from 64 vascular surgeons, cardiothoracic surgeons, and interventional radiologists and recommends the 25th percentile work RVU of 26.75, which accounts for the physician work required to perform this service. The RUC recommends 85 minutes pre-service time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 110 minutes intra-service time, 30 minutes immediate post-service time, 1-99291, 2-99232, 1-99238, 1-99214 and 1-99213 visit, which equals 506 minutes total time.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure*. The selected time package was modified to more accurately reflect pre-service planning collected in the modified survey tool to more accurately reflect pre-service time involved with this service. The specialty society requests 85 minutes of pre-service evaluation time, 13 minutes less than the median survey results and 45 minutes above the standard pre-service package time of 40 minutes. The additional pre-service evaluation time includes 40 minutes for pre-service evaluation plus 45 minutes for pre-planning, which should be bundled in the main procedure and not reported separately per CMS policy. For this service, the pre-planning time review includes confirming the suitability of the anatomy for TEVAR. To do this, a large number of measurements are required, including aortic diameters throughout the aorta, outer and inner curve lengths, center-line lengths from arch vessels to the celiac, subclavian diameters, distance from the left subclavian to the vertebral artery, and diameters of the access vessels (common femoral, external iliac, and common iliac arteries). Additionally, the surgeon assesses the perceived quality of the aorta, particularly in the seal zones, and the tortuosity of the aorta. During this planning, the surgeon reviews all available endograft sizes from several vendors and develops a specific operative plan and device selection that will successfully treat the pathology at hand. This may require ordering specific devices and components which are not readily available at the surgeon's institution. This service is provided after evaluation in the office but more than 24 hours before the procedure, however, is not separately reported.

The specialty society requests 15 minutes of pre-service positioning time which is consistent with the median survey results and 12 minutes above the pre-service package time of 3 minutes. The additional pre-service position time accounts for positioning the imaging equipment and operating room equipment to minimize conflicts between equipment and patients during the surgery, appropriately positioning the patient with arms tucked as indicated, and confirming that all EKG leads and IV, Foley and arterial catheter lines are clear from the areas to be imaged during the procedure. This extra time is 5 minutes less than the positioning time included with abdominal aortic aneurysm endovascular repair codes (34701-34708).

The specialty society selected post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. Regarding post-operative hospital care, the specialty societies provided a detailed rationale to support their recommendation. Among survey respondents, there was a uniform consensus that ICU-level care is provided by the surgeon during the postoperative period. Patients who have undergone thoracic endografting have always been transferred to the ICU immediately post-operatively, but any critical work was generally done by dedicated critical care personnel. Over time, endovascular repair for thoracic pathology has increased from simple aneurysms to now including dissections, penetrating aortic ulcers, and even traumatic ruptures. A wider range of patients with a wider complexity of overall health are being treated with these minimally invasive approaches

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and longer segments of the aorta are now routinely covered, increasing the risk of spinal cord ischemia. Spinal cord ischemia, though uncommon, is a devastating potential complication for any thoracic aortic work, which has always been and is still best understood and managed by the operating surgeon. Thus, it is typical that prophylactic lumbar drains are still used for elective TEVAR cases, as they were required in the primary trial for the TBE device. Lumbar drains are placed by neurosurgery or anesthesiology before surgery in the operating room, and the ongoing measuring of perfusion to the spinal cord, as well as drain management, is managed by the operating surgeon.

Regarding post-operative office visits, the specialty societies noted that survey respondents indicated that while the number of TEVAR post-operative visits has not changed, the visits are now more complex. The first visit, which typically occurs 1-2 weeks following hospital discharge, is a level 3 post-op office visit (99213), wherein incisions are checked, wound care is provided, and a neurovascular assessment is performed. The second visit, which typically occurs 4-6 weeks following hospital discharge, is a level 4 post-op office visit (99214). Much of this time is spent by the operating surgeon reviewing the postoperative CT scan, which is from the aortic arch to the femoral vessels with fine cuts. Three-dimensional software is utilized to evaluate possible endoleaks or other endograft complications, and clinical decisions are made regarding the need for repeat surgical intervention. This work is independent and distinct from any radiologist's interpretation. Given the increased complexity and treatment length of these visits, more work and time is required for the operating surgeon to review these images and discuss them with the patient compared to 20 years ago when these codes were first valued.

To support the recommended work RVU of 26.75, the RUC compared the surveyed code to top key reference code 34701 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 23.71, 120 minutes intra-service time, 482 minutes total time) and second key reference code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service time, 512 minutes total time). The RUC recognized that the two key reference services chosen by survey respondents bracket the 25th percentile work RVU of the surveyed code and total time. Notably, the top key reference service code 34701 requires similar intra-service time and is almost identical in terms of intensity and complexity for the physician to perform.

For additional support, the RUC referenced MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time, 404 minutes total time), noting it requires similar intra-service time as the surveyed code but 102 fewer minutes in pre-service time and post-operative visits. **The RUC recommends a work RVU of 26.75 for CPT code 33381.**

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33882 ***Endovascular repair of the thoracic aorta by deployment of a branched endograft multipiece system involving an aorto-aortic tube device with a fenestration for the left subclavian artery stentgraft(s) and all aortic tube endograft extension(s) placed from the level of the left common carotid artery to the celiac artery, including pre-procedure sizing and device selection, all target zone angioplasty, all nonselective catheterization(s) and left subclavian artery selective catheterization(s), and all associated radiological supervision and interpretation***
The RUC reviewed survey results from 59 vascular surgeons, cardiothoracic surgeons, and interventional radiologists and recommends the 25th percentile work RVU of 39.00, which accounts for the physician work required to perform this service. The RUC recommends 100 minutes pre-service evaluation time, 20 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 180 minutes intra-service time, 40 minutes immediate post-service time, 1-99291, 1-99233, 1-99232, 1-99238, 1-99214, 1-99213 visit, which equals 621 minutes of total time.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure*. The selected time package was modified to more accurately reflect pre-service planning collected in the modified survey tool to more accurately reflect pre-service time involved with this service. The specialty society requests 100 minutes of pre-service evaluation time, 20 minutes less than the median survey results and 60 minutes above the standard pre-service package time of 40 minutes. The additional pre-service evaluation time includes 40 minutes for pre-service evaluation plus 60 minutes for pre-planning, which should be bundled in the main procedure and not reported separately per CMS policy. For this service, the pre-planning time review includes confirming the suitability of the anatomy for TEVAR. To do this, a large number of measurements are required, including aortic diameters throughout the aorta, outer and inner curve lengths, center-line lengths from arch vessels to the celiac, subclavian diameters, distance from the left subclavian to the vertebral artery, and diameters of the access vessels (common femoral, external iliac, and common iliac arteries). Additionally, the surgeon assesses the perceived quality of the aorta, particularly in the seal zones, and the tortuosity of the aorta. During this planning, the surgeon reviews all available endograft sizes from several vendors and develops a specific operative plan and device selection that will successfully treat the pathology at hand. This may require ordering specific devices and components which are not readily available at the surgeon's institution. This service is provided after evaluation in the office but more than 24 hours before the procedure, however, is not separately reported.

The specialty society requests 20 minutes of pre-service positioning time which is consistent with the median survey results and 17 minutes above the pre-service package time of 3 minutes. The additional pre-service position time accounts for positioning the imaging equipment and operating room equipment to minimize conflicts between equipment and patients during the surgery, appropriately positioning the patient with one arm extended and another tucked or positioned over the head, and confirming that all EKG leads and IV, Foley and arterial catheter lines are clear from the areas to be imaged during the procedure. This extra time is identical to the positioning time included with abdominal aortic aneurysm endovascular repair codes (CPT codes 34701-34708). The specialty society recommended, and the RUC concurred, that 40 minutes of immediate post-service time is typical — it is consistent with the median survey results and 7 minutes above the standard post-service package time of 33 minutes. The additional post-service time accounts for time for the physician to complete the operative note, which includes reviewing all images related to the aortic arch vessels, subclavian, and vertebral arteries, annotating appropriate images, dictating radiologic findings, and documenting radiation exposure and contrast volumes. The RUC agreed these changes to the pre-service and post-service time packages are appropriate.

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The specialty society selected post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. Regarding post-operative hospital care, the specialty societies provided a detailed rationale to support their recommendation. Among survey respondents, there was a uniform consensus that ICU-level care is provided by the surgeon during the postoperative period. Patients who have undergone thoracic endografting have always been transferred to the ICU immediately post-operatively, but any critical work was generally done by dedicated critical care personnel. Over time, endovascular repair for thoracic pathology has increased from simple aneurysms to now including dissections, penetrating aortic ulcers, and even traumatic ruptures. A wider range of patients with a wider complexity of overall health are being treated with these minimally invasive approaches and longer segments of the aorta are now routinely covered, increasing the risk of spinal cord ischemia. Spinal cord ischemia, though uncommon, is a devastating potential complication for any thoracic aortic work, which has always been and is still best understood and managed by the operating surgeon. Thus, it is typical that prophylactic lumbar drains are still used for elective TEVAR cases, as they were required in the primary trial for the TBE device. Lumbar drains are placed by neurosurgery or anesthesiology before surgery in the operating room, and the ongoing measuring of perfusion to the spinal cord, as well as drain management, is managed by the operating surgeon.

Regarding post-operative office visits, the specialty societies noted that survey respondents indicated that while the number of TEVAR post-operative visits has not changed, the visits are now more complex. The first visit, which typically occurs 1-2 weeks following hospital discharge, is a level 3 post-op office visit (99213), wherein incisions are checked, wound care is provided, and a neurovascular assessment is performed. The second visit, which typically occurs 4-6 weeks following hospital discharge, is a level 4 post-op office visit (99214). Much of this time is spent by the operating surgeon reviewing the postoperative CT scan, which is from the aortic arch to the femoral vessels with fine cuts. Three-dimensional software is utilized to evaluate possible endoleaks or other endograft complications, and clinical decisions are made regarding the need for repeat surgical intervention. This work is independent and distinct from any radiologist's interpretation. Given the increased complexity and treatment length of these visits, more work and time is required for the operating surgeon to review these images and discuss them with the patient compared to 20 years ago when these codes were first valued.

To support the recommended work RVU of 39.00, the RUC compared the surveyed code to top key reference code 34706 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)* (work RVU = 45.00, 178 minutes intra-service time, 735 minutes total time) and second key reference code 34708 *Endovascular repair of iliac artery by deploysument of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)* (work RVU = 36.50, 120 minutes intra-service time, 677 minutes total time). The RUC recognized that the two key reference services chosen by survey respondents bracket the 25th percentile work RVU of the surveyed code. Notably, the top key reference service code 34706 requires nearly identical intra-service time to perform but requires more and a higher level of post-operative hospital visits.

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For additional support, the RUC referenced MPC code 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts* (work RVU = 39.88, 193 minutes intra-service time, 717 minutes total time), noting it has a very similar work RVU as the surveyed code, albeit slightly higher due to more intra-service time and significantly more total time. **The RUC recommends a work RVU of 39.00 for CPT code 33882.**

33883 ***Delayed placement of proximal extension prosthesis(es) not involving coverage of the left subclavian artery origin, after endovascular repair of the thoracic aorta, including pre-procedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed***
The RUC reviewed survey results from 61 vascular surgeons, cardiothoracic surgeons, and interventional radiologists and recommends the 25th percentile work RVU of 24.25, which accounts for the physician work required to perform this service. The RUC recommends 85 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time, 1-99291, 2-99232, 1-99238, 1-99214 and 1-99213 visit, which equals 486 minutes of total time.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure*. The selected time package was modified to more accurately reflect pre-service planning collected in the modified survey tool to more accurately reflect pre-service time involved with this service. The specialty society requests 85 minutes of pre-service evaluation time, 5 minutes less than the median survey results and 45 minutes above the standard pre-service package time of 40 minutes. The additional pre-service evaluation time includes 40 minutes for pre-service evaluation plus 45 minutes for pre-planning, which should be bundled in the main procedure and not reported separately per CMS policy. For this service, the pre-planning time review includes confirming the suitability of the anatomy for TEVAR. To do this, a large number of measurements are required, including aortic diameters throughout the aorta, outer and inner curve lengths, center-line lengths from arch vessels to the celiac, subclavian diameters, distance from the left subclavian to the vertebral artery, and diameters of the access vessels (common femoral, external iliac, and common iliac arteries). Additionally, the surgeon assesses the perceived quality of the aorta, particularly in the seal zones, and the tortuosity of the aorta. During this planning, the surgeon reviews all available endograft sizes from several vendors and develops a specific operative plan and device selection that will successfully treat the pathology at hand. This may require ordering specific devices and components which are not readily available at the surgeon's institution. This service is provided after evaluation in the office but more than 24 hours before the procedure, however, is not separately reported.

The specialty society requests 15 minutes of pre-service positioning time which is consistent with the median survey results and 12 minutes above the pre-service package time of 3 minutes. The additional pre-service position time accounts for positioning the imaging equipment and operating room equipment to minimize conflicts between equipment and patients during the surgery, appropriately positioning the patient with arms tucked as indicated, and confirming that all EKG leads and IV, Foley and arterial catheter lines are clear from the areas to be imaged during the procedure. This extra time is 5 minutes less than the positioning time included with abdominal aortic aneurysm endovascular repair codes (34701-34708).

The specialty society selected post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. Regarding post-operative hospital care, the specialty societies provided a detailed rationale to support their recommendation. Among survey respondents, there was a uniform consensus that ICU-level care is provided by the surgeon during the postoperative period. Patients who have undergone thoracic endografting have always been transferred to the ICU immediately

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post-operatively, but any critical work was generally done by dedicated critical care personnel. Over time, endovascular repair for thoracic pathology has increased from simple aneurysms to now including dissections, penetrating aortic ulcers, and even traumatic ruptures. A wider range of patients with a wider complexity of overall health are being treated with these minimally invasive approaches and longer segments of the aorta are now routinely covered, increasing the risk of spinal cord ischemia. Spinal cord ischemia, though uncommon, is a devastating potential complication for any thoracic aortic work, which has always been and is still best understood and managed by the operating surgeon. Thus, it is typical that prophylactic lumbar drains are still used for elective TEVAR cases, as they were required in the primary trial for the TBE device. Lumbar drains are placed by neurosurgery or anesthesiology before surgery in the operating room, and the ongoing measuring of perfusion to the spinal cord, as well as drain management, is managed by the operating surgeon.

Regarding post-operative office visits, the specialty societies noted that survey respondents indicated that while the number of TEVAR post-operative visits has not changed, the visits are now more complex. The first visit, which typically occurs 1-2 weeks following hospital discharge, is a level 3 post-op office visit (99213), wherein incisions are checked, wound care is provided, and a neurovascular assessment is performed. The second visit, which typically occurs 4-6 weeks following hospital discharge, is a level 4 post-op office visit (99214). Much of this time is spent by the operating surgeon reviewing the postoperative CT scan, which is from the aortic arch to the femoral vessels with fine cuts. Three-dimensional software is utilized to evaluate possible endoleaks or other endograft complications, and clinical decisions are made regarding the need for repeat surgical intervention. This work is independent and distinct from any radiologist's interpretation. Given the increased complexity and treatment length of these visits, more work and time is required for the operating surgeon to review these images and discuss them with the patient compared to 20 years ago when these codes were first valued.

To support the recommended work RVU of 24.25, the RUC compared the surveyed code to top key reference code 34701 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 23.71, 120 minutes intra-service time, 482 minutes total time) and second key reference code 34708 *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)* (work RVU = 36.50, 120 minutes intra-service time, 677 minutes total time). The RUC recognized that the two key reference services chosen by survey respondents bracket the 25th percentile work RVU of the surveyed code. Notably, the top key reference service code 34701 requires nearly identical total time and intensity to perform as the surveyed code. The second key reference service requires more intra-service time and total time as the surveyed code and is appropriately valued higher.

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For additional support, the RUC referenced MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time, 404 minutes total time), noting it has a similar work RVU as the surveyed code overall. Although it requires more intra-service time, CPT code 35301 has less total time and requires less intensity to perform than the surveyed code. **The RUC recommends a work RVU of 24.25 for CPT code 33883.**

33886 ***Delayed placement of distal extension prosthesis(es) from the level of the left subclavian artery to the celiac artery, after endovascular repair of descending thoracic aorta, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation***

The RUC reviewed survey results from 61 vascular surgeons, cardiothoracic surgeons, and interventional radiologists and recommends the 25th percentile work RVU of 23.50, which accounts for the physician work required to perform this service. The RUC recommends 85 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time, 1-99291, 2-99232, 1-99238, 1-99214 and 1-99213 visit, which equals 486 minutes of total time.

The physician work involved with CPT codes 33886 and 33883 is nearly identical. Notably, CPT code 33886 describes endovascular repair with a distal extension prosthesis, which can be distinguished from CPT code 33883, which describes endovascular repair with a proximal extension prosthesis, the former service being slightly more intense to perform for the surgeon and thus requiring slightly more physician work overall.

The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure*. The selected time package was modified to more accurately reflect pre-service planning collected in the modified survey tool to more accurately reflect pre-service time involved with this service. The specialty society requests 85 minutes of pre-service evaluation time, 5 minutes less than the median survey results and 45 minutes above the standard pre-service package time of 40 minutes. The additional pre-service evaluation time includes 40 minutes for pre-service evaluation plus 45 minutes for pre-planning, which should be bundled in the main procedure and not reported separately per CMS policy. For this service, the pre-planning time review includes confirming the suitability of the anatomy for TEVAR. To do this, a large number of measurements are required, including aortic diameters throughout the aorta, outer and inner curve lengths, center-line lengths from arch vessels to the celiac, subclavian diameters, distance from the left subclavian to the vertebral artery, and diameters of the access vessels (common femoral, external iliac, and common iliac arteries). Additionally, the surgeon assesses the perceived quality of the aorta, particularly in the seal zones, and the tortuosity of the aorta. During this planning, the surgeon reviews all available endograft sizes from several vendors and develops a specific operative plan and device selection that will successfully treat the pathology at hand. This may require ordering specific devices and components which are not readily available at the surgeon's institution. This service is provided after evaluation in the office but more than 24 hours before the procedure, however, is not separately reported.

The specialty society requests 15 minutes of pre-service positioning time which is consistent with the median survey results and 12 minutes above the pre-service package time of 3 minutes. The additional pre-service position time accounts for positioning the imaging equipment and operating room equipment to minimize conflicts between equipment and patients during the surgery, appropriately positioning the patient with arms tucked as indicated, and confirming that all EKG leads and IV, Foley and arterial catheter lines are clear from the areas to be imaged during the procedure. This extra time is 5 minutes less than the positioning time included with abdominal aortic aneurysm endovascular repair codes (34701-34708).

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The specialty society selected post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. Regarding post-operative hospital care, the specialty societies provided a detailed rationale to support their recommendation. Among survey respondents, there was a uniform consensus that ICU-level care is provided by the surgeon during the postoperative period. Patients who have undergone thoracic endografting have always been transferred to the ICU immediately post-operatively, but any critical work was generally done by dedicated critical care personnel. Over time, endovascular repair for thoracic pathology has increased from simple aneurysms to now including dissections, penetrating aortic ulcers, and even traumatic ruptures. A wider range of patients with a wider complexity of overall health are being treated with these minimally invasive approaches and longer segments of the aorta are now routinely covered, increasing the risk of spinal cord ischemia. Spinal cord ischemia, though uncommon, is a devastating potential complication for any thoracic aortic work, which has always been and is still best understood and managed by the operating surgeon. Thus, it is typical that prophylactic lumbar drains are still used for elective TEVAR cases, as they were required in the primary trial for the TBE device. Lumbar drains are placed by neurosurgery or anesthesiology prior to surgery in the operating room, and the ongoing measuring of perfusion to the spinal cord, as well as drain management, is managed by the operating surgeon.

Regarding post-operative office visits, the specialty societies noted that survey respondents indicated that while the number of TEVAR post-operative visits has not changed, the visits are now more complex. The first visit, which typically occurs 1-2 weeks following hospital discharge, is a level 3 post-op office visit (99213), wherein incisions are checked, wound care is provided, and a neurovascular assessment is performed. The second visit, which typically occurs 4-6 weeks following hospital discharge, is a level 4 post-op office visit (99214). Much of this time is spent by the operating surgeon reviewing the postoperative CT scan, which is from the aortic arch to the femoral vessels with fine cuts. Three-dimensional software is utilized to evaluate possible endoleaks or other endograft complications, and clinical decisions are made regarding the need for repeat surgical intervention. This work is independent and distinct from any radiologist's interpretation. Given the increased complexity and treatment length of these visits, more work and time is required for the operating surgeon to review these images and discuss them with the patient compared to 20 years ago when these codes were first valued.

To support the recommended work RVU of 23.50, the RUC compared the surveyed code to top key reference code 34701 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 23.71, 120 minutes intra-service time, 482 minutes total time) and second key reference code 34718 *Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral* (work RVU = 24.00, 120 minutes intra-service time, 477 minutes total time). The RUC recognized that the surveyed code is comparable to the two key reference services in terms of total time and overall intensity and complexity. The surveyed code requires less intra-service time than the two key reference services, thus justifying it having a lower work RVU. The top key reference service code 34701 has identical intra-service time compared to the surveyed code, but the

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surveyed code requires less total time and is a less intense procedure for the physician to perform, thus justifying a lesser work RVU.

For additional support, the RUC referenced MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time, 404 minutes total time), noting it has a similar work RVU as the surveyed code overall. Although it requires more intra-service time, CPT code 35301 has less total time and requires less intensity to perform than the surveyed code. **The RUC recommends a work RVU of 23.50 for CPT code 33886.**

35602 ***Bypass graft, with other than vein; carotid-contralateral carotid***
The RUC reviewed survey results from 52 vascular surgeons and cardiothoracic surgeons and recommends the 25th percentile work RVU of 27.40, which accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 150 minutes intra-service time, 30 minutes immediate post-service time, 1-99233, 2-99232, 1-99238, 1-99214 and 1-99213 visit, which equals 486 minutes of total time.

Notably, CPT code 35602 has a 090-day global period and replaces existing CPT code 33891, which has a 000-day global period. The specialty society selected pre-service time package *4-FAC Difficult Patient/Difficult Procedure*. The selected time package was modified to more accurately reflect pre-service time involved with this service. Unlike the other codes in the TEVAR family, CPT code 35602 does not include any bundled pre-planning time review. Thus, the specialty society requests 40 minutes of pre-service evaluation time which is consistent with the standard pre-service package time and 43 minutes less than the median survey results.

The specialty society requests 15 minutes of pre-service positioning time, 2 minutes less than the median survey results and 12 minutes above the pre-service package time of 3 minutes. The additional pre-service position time accounts for the time needed for the neck incision. The patient is placed in the "beach chair" position, and a shoulder role is typically placed. The neck is placed in the neutral position but should be free to move from side to side depending on which carotid is being operated on at the specific moment as both carotids will ultimately be dissected. This positioning is done in concert with anesthesia to ensure the endotracheal tube is not dislodged and does not become dislodged during the surgery. The endotracheal tube is secured appropriately under the observation of the surgeon to ensure an appropriate field for skin preparation. The extra positioning time is consistent with other vascular codes involving carotid dissection.

The specialty society selected post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. Regarding post-operative hospital care, the specialty societies provided a detailed rationale to support their recommendation. Among survey respondents, there was a uniform consensus that these patients are typically managed in the ICU following surgery, though, unlike the other codes in this family, the surgeon does not provide any of the critical care time. Typically, an intensivist provides care for blood pressure and other critical care needs, while the surgeon guides the specific parameters to be followed. The first day requires a 99233 visit, and when the patient is transferred out of the ICU, all care, including neurologic assessments and blood pressure control, is performed by the surgeon. These additional visits are of moderate complexity.

Regarding post-operative office visits, the specialty societies noted that survey respondents indicated that while the number of TEVAR post-operative visits has not changed, the visits are now more complex. The first visit, which typically occurs 1-2 weeks following hospital discharge, is a level 3 post-op office visit (99213), wherein incisions are checked, wound care is provided, and a

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neurovascular assessment is performed. The second visit, which typically occurs 4-6 weeks following hospital discharge, is a level 4 post-op office visit (99214). A neurovascular assessment is again performed. Additional time is spent by the operating surgeon reviewing postoperative imaging, either ultrasound, CT, physiologic testing, or some combination of all these. Clinical decisions are made regarding the need for repeat surgical intervention. This work is distinct from any radiologist's interpretation.

To support the recommended work RVU of 27.40, the RUC compared the surveyed code to top key reference code 35601 *Bypass graft, with other than vein; common carotid-ipsilateral internal carotid* (work RVU = 27.09, 180 minutes intra-service time, 484 minutes total time) and second key reference code 35606 *Bypass graft, with other than vein; carotid-subclavian* (work RVU = 22.46, 145 minutes intra-service time, 414 minutes total time). The RUC recognized that the surveyed code is appropriately compared to the two key reference services in terms of intra-service time and total time, as well as relative intensity and complexity. The top key reference service code 35601 requires nearly identical total time compared to the surveyed code, and more intra-service time but is a less intense procedure for the physician to perform. The second key reference service, code 35606, requires nearly identical intra-service time but less total time than the surveyed code and is also less intense to perform than the surveyed code. Notably, the two key reference services chosen by survey respondents bracket the survey 25th percentile of the surveyed code despite lesser intensity. The specialty societies noted that there are many clinical scenarios where this service would be applicable, not just in conjunction with TEVAR, resulting in a range of intensities.

For additional support, the RUC referenced CPT code 34703 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 26.52, 150 minutes intra-service time, 507 minutes total time). The RUC noted that the CPT code 34703 is an appropriate reference service, as it has identical intra-service time, similar total time, and is comparable in terms of the intensity required for the physician to perform. **The RUC recommends a work RVU of 27.40 for CPT code 35602.**

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. New code 33882 was created to describe a new stent that accommodates the left subclavian artery, thus new technology/technique. And the bypass code 35602 is changing from a 000-day global to a 090-day global. Compelling evidence was accepted based on new technology and change in global period.

The PE Subcommittee reviewed the direct practice expense inputs and made a single modification to the standard 090-day global inputs. Supply item SA053 *pack, post-op incision care (suture & staple)* was changed to SA052 *pack, post-op incision care (staple)* for the code family as the typical incision would be closed with staples. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT code 33882 will be placed on the New Technology list to be reviewed by the RUC in three years.

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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.

Lower Extremity Revascularization (Tab 6)
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Facilitation Committee #1

In October 2018, CPT codes 37225, 37227 and 37229 were identified by the Relativity Assessment Workgroup's (RAW's) PE High-Cost Supplies screen for services with non-facility Medicare utilization over 10,000, which were not reviewed in the last five years and include a supply item greater than $500. The RUC requested an action plan for the January 2019 RUC meeting proposing how to address these flagged services. The RAW reviewed the action plan for these services and noted that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing activity was appropriate. The RAW noted that CPT code 37229 was also identified on the High-Volume Growth screen at that meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies. The specialty societies worked with the CPT Editorial Panel and submitted multiple code change applications (CCAs). In September 2021, the CPT Editorial Panel did not approve of the proposed coding changes which suggested unbundling previous bundling efforts.

Since this issue was not addressed via the CPT process in September 2021, it was placed back on the RAW agenda for review. In April 2022, the RAW discussed the complexity of this issue and determined that coding clarification was still necessary. The RAW recommended that a joint CPT/RUC Workgroup be created to develop coding solutions for the endovascular revascularization (37220-37235) code family. In September 2022, CPT indicated the specialty societies should develop a CCA by the May 2024 CPT meeting. The specialties successfully submitted a CCA for the September 2024 CPT Editorial Panel meeting. The CPT Editorial Panel created four new subsections and 46 new codes to report lower extremity revascularization (LER) services. The 16 existing codes (37220-37235) to report these services were deleted.

The CPT Editorial Panel updated the code set to include more granularity to better reflect the large changes in technology and standards of practice since the code family was last updated 13 years ago, including the migration of many of these services to the outpatient and non-facility settings. The code set was updated to more appropriately recognize the variation in physician work and practice expense when LER services are performed for a stenosis (ie a straightforward lesion) versus an occlusion (ie a complex lesion), when these procedures are performed in multiple vessels in the same territory, and to recognize that certain services require specific balloons, stents, catheters and/or atherectomy devices depending on what vessel is typically being treated.

The specialties noted and the RUC concurred that the consequences of a complication with distal embolization or rupture of the vessel, which are risks for LER procedures, can lead to worsening circulation in the patient and can lead to amputation. It can create a patient that has a chronic ischemia or turn the patient into an acute ischemia, where the patient would need to go directly from the lab to an operating room to try to bypass or reestablish blood flow. The risks of complications are present with all lower extremity revascularizations, though they are higher with complex lesions, increasing the intensity of physician work for these services.

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New Coding Structure
This code family includes 22 new 000-day global codes which are now differentiated between straightforward or complex lesions and cover 4 different vascular territories. The new code structure maintains a unilateral coding structure, where add-on codes would only reported if there is a second or subsequent vessel treated in the same territory and the same leg. A straightforward lesion is defined as a stenosis and a complex lesion is defined as an occlusion. When a procedure involves lesions in more than one vascular territory, then these services are subject to CMS' multiple procedure payment reduction policy. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not previously include add-on codes under the legacy coding structure – instead, that territory previously included only base codes that were for one or more vessels in that territory. The code family now includes 22 new add-on codes that describe performing these services on additional vessels and 2 add-on codes for reporting intravascular lithotripsy(ies). There are codes specific to balloon transluminal angioplasty (TA), stent with TA, atherectomy with TA, stent and atherectomy with TA and lithotripsy of calcified vessels. Codes 37254-37299 include:

1. All maneuvers necessary for
    a. accessing and selectively catheterizing the artery,
    b. crossing the lesion, and
    c. performing the endovascular intervention
2. All imaging
    a. for intraprocedural guidance including radiological supervision and interpretation directly related to the intervention performed,
    b. to document completion of the intervention, and
    c. to document completion of the procedure
3. Embolic protection if used; and
4. Closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture.

Research-Approved Custom Survey Methodology
In September 2024, the Research Subcommittee approved a custom survey methodology which included conducting a standard RUC survey of 11 anchor codes for the family and then conducting an abbreviated survey for the other 35 codes. The 11 anchor codes represented every territory in the family, straightforward procedures, complex procedures, angioplasty only procedures, stent placement procedures, atherectomy procedures and add-on procedures. The 35 abbreviated survey codes were split into two groups and survey respondents only received one of those two groups along with the 11 core codes. There were two notable changes made to the abbreviated survey. First, survey respondents were provided with one of the anchor codes as a comparator instead of using a reference service list; second, survey respondents were only asked one question per abbreviated code in the intensity/complexity section.

Compelling Evidence
The RUC reviewed compelling evidence based on a change in technology, change in patient population and change in site of service. The specialties noted that there have also been significant changes to existing technology over the past 15 years including drug coated balloons, drug-eluting stents, newer atherectomy devices, and advanced wires/catheters to treat more complex lesions. They also noted that this evolution of technology and techniques has allowed the expansion of endovascular revascularization to patients with more advanced diseases and more complex patients. Therefore, the complexity and pathology of the typical patient is significantly different today. As both techniques and technology have developed over the years, the shift of procedures from open surgical bypass to endovascular has continued. In addition, patients who were previously thought to be poor candidates for revascularization (either through surgical or endovascular methods) are now being

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routinely treated with documented safety. Advanced age, extensive arterial occlusive disease and advanced limb ischemia are no longer exclusion criteria for endovascular revascularization and for that reason, the patient population has significantly changed.

Prior to 2010, the vast majority of lower extremity revascularization was performed in the hospital setting. At that time, the non-facility inputs created in 2010 allowed the migration of patient care out of the facility and into the non-facility setting as it became apparent that these procedures were able to be performed safely and more efficiently. The shift in site of service also results in compelling evidence for valuation. **The RUC accepted compelling evidence based on changes in technology, patient population, and site of service.**

General Relativity within the Lower Extremity Revascularization Code Family
The RUC reviewed intra-family relativity across three main dimensions: straightforward to complex, proximal to distal territories, and increasing complexity of interventions. The RUC concurred with the specialties that the hierarchy of treatment modalities from simple to difficult is angioplasty < stent < atherectomy. It was also agreed upon that interventions increase in time and difficulty with progression from larger vessels to smaller vessels, i.e., iliac < femoral/popliteal < tibial < inframalleolar.

As part of their deliberations, the RUC noted that in general the survey data was robust. However, in order to ensure proper relativity within a 46 code family, it would sometimes be appropriate to use direct work RVU crosswalks. The RUC noted that the second page of the summary spreadsheet, titled "Delta," provides additional context on the relativity within the code family.

Pre-service and Post-service Time
The RUC adjusted the times to be consistent with the survey pre-service time for each 000-day global code to reflect the time typically required to perform the pre-service evaluation and other work to prepare for the procedure. The evaluation time beyond the standard package time includes time for selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The positioning time beyond the standard package time includes positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required to be able to obtain all necessary views to treat the lesion. The immediate post-service time beyond the standard package time includes time to document the additional radiologic supervision and interpretation portion of the procedure in the operative note.

Iliac Vascular Territory (37254-37262)

37254 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 7.30 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, 30 minutes immediate post-service time. This would be reported for an initial vessel with stenosis in the iliac vascular territory.

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To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU= 9.00, intra-service time= 75, total time= 126) and noted that the surveyed code typically involves 15 minutes less intra-service time and is a somewhat less intense service to perform. The RUC also compared the survey code to second key reference code 36253 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 7.30, intra-service time= 60, total time= 121) and determined that both services typically involve the same amount of intra-service time, similar total time and the same overall amount of physician work. **The RUC recommends a work RVU of 7.30 for CPT code 37254.**

37255 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 3.00 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes intra-service and total time. This would be reported for a stenosis after treating an initial iliac vessel on the ipsilateral side.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, intra-service time and total time= 30) and noted that both services typically involve the same amount of time, though the reference code is somewhat more intense to perform. The RUC also compared the surveyed code to CPT code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service time and total time= 40) and noted that the surveyed code typically involves 10 fewer minutes and would have appropriate relativity to this reference code. **The RUC recommends a work RVU of 3.00 for CPT code 37255.**

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37256 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 10.75 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 80 minutes intra-service time, 30 minutes immediate post-service time. This procedure would typically be in the common iliac artery. This procedure describes an angioplasty for an occlusion where it requires the additional work of crossing the occluded vessel and reentering the true lumen beyond the occlusion, which greatly increases the intensity and risk of complications for this procedure.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and determined that although the surveyed code involves less intra-service time, it involves more total time and is slightly more intense to perform. **The RUC recommends a work RVU of 10.75 for CPT code 37256.**

37257 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 3.89 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 36 minutes intra-service and total time. This add-on code describes an angioplasty for an occlusion which requires the additional work of crossing the occluded vessel and reentering the true lumen beyond the occlusion, which greatly increases the intensity and risk of complications for this procedure.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37255 (recommended work RVU= 3.00, intra-service and total time= 30) to ensure appropriate relativity within the family and noted that both services typically involve the same amount of time, though 37257 is more intense as it is for a complex lesion. For further support, the RUC also referenced CPT Code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, intra-service time and total time= 30) and noted that both

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services are valued similarly and have similar times. **The RUC recommends a work RVU of 3.89 for CPT code 37257.**

37258 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 8.75 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 75 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37254 (recommended work RVU= 7.30, intra-service time= 60, total time= 128) to ensure appropriate relativity within the family and determined that 37258 code typically involves 15 more minutes of time and a more complex treatment modality. For further support, the RUC also referenced CPT code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU= 9.00, intra-service time= 75, total time= 126) and noted that both services typically involve the same intra-service time. **The RUC recommends a work RVU of 8.75 for CPT code 37258.**

37259 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 4.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 40 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37255 (recommended work RVU= 3.00, intra-service and total time= 30) to ensure appropriate relativity within the family and determined that 37259 typically involves 10 more minutes of time and includes a more intensive treatment modality. For further support, the RUC also referenced CPT Code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, intra-service and total time= 30) and noted that the surveyed code typically

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involves 10 more minutes of time. **The RUC recommends a work RVU of 4.00 for CPT code 37259.**

37260 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 12.69 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 117 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37256 (recommended work RVU= 10.75, intra-service time= 80, total time= 148) to ensure appropriate relativity within the family and determined that 37256 typically involves 37 more minutes and a more intensive treatment modality. For further support, the RUC also referenced CPT code 49594 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated* (work RVU= 13.46, intra-service time= 120, total time= 225) and noted that the reference code involves similar intra-service time and somewhat more total time. **The RUC recommends a work RVU of 12.69 for CPT code 37260.**

37261 ***Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the survey 25th percentile work RVU of 4.25 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 44 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37255 (recommended work RVU= 3.00, intra-service time= 30, total time= 30) to ensure appropriate relativity within the family and determined that 37261 involves 14 more minutes of time and describes a complex lesion. For further support, the RUC also referenced CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated* (List separately in addition to code for primary procedure) (work RVU= 6.50, intra-service and total time= 60) and noted that the reference code involves 16 more minutes of time and has appropriate relativity to the surveyed code. **The RUC recommends a work RVU of 4.25 for CPT code 37261.**

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37262 ***Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 3.00 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes intra-service and total time.

Intravascular lithotripsy is a new technology combining angioplasty with lithotripsy specifically for lesions that are heavily calcified. The balloon is inserted over a wire and inflated to where contact is made with the balloon in the vessel wall. The catheter is then connected to a generator, and pulses of ultrasonic energy are emitted from multiple transducers within the balloon itself, and transmitted through the fluid in the balloon into the wall of the vessel with the idea of causing microfractures within the calcium of the wall, so that the vessel can respond better to a standard angioplasty and/or a stent.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service and total time= 40) and determined that the key reference code typically involves 10 more minutes and both codes would have appropriate relativity. The RUC also compared the survey code to second key reference code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, intra-service and total time= 30) and noted that the surveyed code is somewhat less intense to perform. **The RUC recommends a work RVU of 3.00 for CPT code 37262.**

Femoral and Popliteal Vascular Territory (37263-37279)

37263 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 48 surgeons and determined a direct work RVU crosswalk to CPT code 37211 *Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day* (work RVU= 7.75, intra-service time= 60, total time= 128) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of intra-service time and total time, as well as the same overall amount of physician work. The surveyed code is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. The presenters noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions

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in the femoral and popliteal territory are typically of greater length, require more time to perform and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37267 (recommended work RVU= 8.75, intra-service time= 75, total time= 143) and determined that both codes maintain the appropriate relativity in this family of services. This reference code typically requires more time and involves a treatment modality that is also somewhat more intense (stent placement with angioplasty, when performed versus angioplasty alone). For further support, the RUC also referenced CPT code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU= 9.00, intra-service time= 75, total time= 126) and noted that the surveyed code typically involves 15 minutes less of intra-service time, and would have appropriate relativity with this reference code. **The RUC recommends a work RVU of 7.75 for CPT code 37263.**

37264 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 3.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service time= 35, total time= 35) to ensure appropriate relativity within the family and determined that 37264 typically involves 5 less minutes and a less complex treatment modality (angioplasty alone versus stent placement with angioplasty, when performed). The RUC also referenced CPT code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, intra-service time= 30, total time= 30), which involves the same amount of time, though is somewhat more intense to perform. **The RUC recommends a work RVU of 3.00 for CPT code 37264.**

37265 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 10.50 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-

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service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. The presenters noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform, and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37269 (recommended work RVU= 14.75, intra-service time= 110, total time= 178) to ensure appropriate relativity within the family and determined that 37265 typically involves 20 minutes less intra-service and total time and a less complex treatment modality (angioplasty alone versus stent placement with angioplasty, when performed). The RUC also compared the survey code to CPT code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that both codes typically involve an identical amount of intra-service time and a similar amount of total time. **The RUC recommends a work RVU of 10.50 for CPT code 37265.**

37266 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 4.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 40 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service time= 35, total time= 35) to ensure appropriate relativity within the family and determined that 37266 typically involves 5 more minutes and a complex lesion. The RUC also referenced CPT code 44128 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU= 4.44, intra-service and total time= 40) and noted that both services typically involve the same amount of time, though the reference code is somewhat more intense to perform typically. **The RUC recommends a work RVU of 4.00 for CPT code 37266.**

37267 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***

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The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 8.75 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 75 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. This is typically performed in the vessel in the whole family is the longest vessel treated, the superficial femoral popliteal vessel, which will average somewhere around 40 cm, depending on the height of the patient. The specialty societies noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and determined that the surveyed code typically involves 15 minutes less intra-service time. The RUC also compared the survey code to second key reference code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU= 9.00, intra-service time= 75, total time= 126) and noted that both services involve the same amount of intra-service time and a similar amount of physician work. **The RUC recommends a work RVU of 8.75 for CPT code 37267.**

37268 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 3.73 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 35 minutes of intra-service and total time. Add-on codes did not exist in the previous code structure for this vascular territory.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately*

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in addition to code for primary procedure) (work RVU= 4.25, intra-service and total time= 40) and noted that the surveyed code typically involves 5 minutes less of intra-service and total time. The RUC also compared the survey code to the second key reference code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU= 6.50, intra-service time= 60, total time= 60) and noted that the reference code typically involves 25 minutes more of intra-service and total time. **The RUC recommends a work RVU of 3.73 for CPT code 37268.**

37269 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***

The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 14.75 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 110 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. This is typically performed in the vessel in the whole family is the longest vessel treated, the superficial femoral popliteal vessel, which will average somewhere around 40 cm, depending on the height of the patient The specialty societies noted that this is the service with the highest physician work intensity in the code family. The presenters noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform, and are more intense than a comparative iliac lesion.

The presenters noted that these complex chronic total occlusions of the superficial femoral popliteal artery can have very long occlusions. They often require advanced techniques to cross the lesion. Often, the surgeons use advanced reentry catheters as part of this procedure.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU= 15.00, intra-service time= 100, total time= 241) and noted that, although the surveyed code involves 10 more minutes of intra-service time, the reference code involves more total time. The RUC also compared the survey code to the second key reference code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total

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time= 141) and noted that the surveyed code typically involves much more time and work to perform. **The RUC recommends a work RVU of 14.75 for CPT code 37269.**

37270 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 5.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 52 minutes intra-service time and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service and total time= 35) to ensure appropriate relativity within the family and determined that 37270 typically involves 17 more minutes and describes a complex lesion. The RUC also referenced CPT code 34715 *Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral* (work RVU= 6.00, intra-service and total time= 60) and noted that the surveyed code typically involves 8 minutes less of intra-service and total time, as well as somewhat less physician work. **The RUC recommends a work RVU of 5.00 for CPT code 37270.**

37271 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 9.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. The presenters noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37267 (recommended work RVU= 8.75, intra-service time= 75, total time= 143) to ensure appropriate relativity within the family and determined that 37271 typically involves 15 more minutes of time and a more complex treatment modality (atherectomy with angioplasty, when performed versus stent placement with angioplasty, when performed). The RUC also compared the survey code to CPT code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and*

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intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty (work RVU= 9.00, intra-service time= 75, total time= 126) and noted that although the surveyed code involves more time, it is a somewhat less intense service to perform. **The RUC recommends a work RVU of 9.00 for CPT code 37271.**

37272 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 4.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 43 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service time= 35, total time= 35) to ensure appropriate relativity within the family and determined that the 37272 typically involves 8 more minutes of time and a more complex treatment modality (atherectomy with angioplasty, when performed versus stent placement with angioplasty, when performed). The RUC also compared the survey code to CPT code 37237 *Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery* (work RVU= 4.25, intra-service time= 45, total time= 47) and noted that the reference code involves slightly more intra-service and total time. **The RUC recommends a work RVU of 4.00 for CPT code 37272.**

37273 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 12.63 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 118 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other 3 vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. The presenters noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 49594 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis*

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when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated (work RVU= 13.46, intra-service time= 120, total time= 225) and noted that both codes involve a similar amount of intra-service time, the reference code involves more total time and the surveyed code has higher level of physician work intensity. The RUC also compared the survey code to CPT code 49621 *Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible* (work RVU= 13.70, intra-service= 120 minutes, total time= 220 minutes) and noted that both services also involve a similar amount of intra-service time, though the reference code involves more total time. **The RUC recommends a work RVU of 12.63 for CPT code 37273.**

37274 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 5.50 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 60 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service and total time= 35) to ensure appropriate relativity within the family and noted that 37274 typically 25 more minutes of time as it involves a complex patient and a more intensive treatment modality (atherectomy with angioplasty, when performed versus stent placement with angioplasty, when performed). For further support, the RUC also referenced CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated* (List separately in addition to code for primary procedure) (work RVU= 6.50, intra-service and total time= 60). **The RUC recommends a work RVU of 5.50 for CPT code 37274.**

37275 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***

The RUC reviewed the survey results from 48 surgeons and determined that the 25th percentile work RVU of 11.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 115 minutes intra-service time, 30 minutes immediate post-service time. Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. The presenters noted that the femoral and

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popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37267 (recommended work RVU= 8.75, intra-service time= 75, total time= 143) and noted that 37275 typically involves 40 more minutes of intra-service and total time, as although both services involve the placement of a stent, 37275 also involves an atherectomy. The RUC also compared the survey code to CPT code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that the surveyed code involves 15 more minutes of intra-service time and 42 more minutes of total time. **The RUC recommends a work RVU of 11.00 for CPT code 37275.**

37276 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 48 surgeons and determined a direct work RVU crosswalk to CPT code 37237 *Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery* (work RVU= 4.25, intra-service time= 45, total time= 47) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of time and the same overall amount of physician work. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 45 minutes intra-service time and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service time= 35, total time= 35) to ensure appropriate relativity within the family and noted that 37276 includes 10 more minutes of time and involves a more intense treatment modality (stent placement with atherectomy and angioplasty, when performed versus stent placement with angioplasty, when performed). The RUC also referenced CPT code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service time= 40, total time= 40). **The RUC recommends a work RVU of 4.25 for CPT code 37276.**

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37277 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium…* (work RVU= 15.00, intra-service time of 120 minutes, total time of 199 minutes) and noted that both services typically involve a similar amount of time and the same overall amount of physician work. CPT code 37277 is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 123 minutes intra-service time, 30 minutes immediate post-service time.

Unlike the other three vascular territories, the femoral and popliteal vascular territory did not have any add-on codes under the legacy coding structure. The presenters noted that the femoral and popliteal vascular territory is deeper and generally more complex than the iliac vascular territory. The specialty societies noted that the lesions in the femoral and popliteal territory are typically of greater length, require more time to perform and are more intense than a comparative iliac lesion.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37269 (recommended work RVU= 14.75, intra-service time= 110, total time= 178) to ensure appropriate relativity within the family and determined that both services have appropriate relativity to one another. The RUC also referenced 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU= 15.00, intra-service time= 100, total time= 241). **The RUC recommends a work RVU of 15.00 for CPT code 37277.**

37278 ***Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 6.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends minutes pre-service evaluation time, minutes pre-service positioning time, minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, minutes immediate post-service time.

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To support the recommended work RVU, the RUC compared the surveyed code to core family code 37268 (recommended work RVU= 3.73, intra-service time= 35, total time= 35) to ensure appropriate relativity within the family and determined that code 37278 typically involves 25 more minutes of time. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU= 7.00, intra-service time= 60, total time= 60) and noted that although both services typically involve the same amount of time, the surveyed code is a somewhat less intensive service to perform. **The RUC recommends a work RVU of 6.00 for CPT code 37278.**

37279 ***Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined that the median work RVU of 4.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 40 minutes intra-service and total time.

Intravascular lithotripsy is a new technology combining angioplasty with lithotripsy specifically for lesions that are heavily calcified. The balloon is inserted over a wire and inflated to where contact is made with the balloon in the vessel wall. The catheter is then connected to a generator, and pulses of ultrasonic energy are emitted from multiple transducers within the balloon itself, and transmitted through the fluid in the balloon into the wall of the vessel with the idea of causing microfractures within the calcium of the wall, so that the vessel can respond better to a standard angioplasty and/or a stent.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37262 (recommended work RVU= 3.00, intra-service time= 30, total time= 30) to ensure appropriate relativity within the family and noted that 37279 typically involves 10 more minutes of time and is performed in a territory that has smaller vessels. The RUC also referenced CPT code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service time= 40, total time= 40). **The RUC recommends a work RVU of 4.00 for CPT code 37279.**

Tibial and Peroneal Vascular Territory (37280-37295)

37280 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 9.80 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time.

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To support the recommended work RVU, the RUC compared the surveyed code to core family code 37288 (recommended work RVU= 13.50, intra-service time= 120, total time= 188) to ensure appropriate relativity within the family and noted that 37280 typically takes 30 minutes less time and, unlike 37288, does not include the work of an atherectomy. The RUC also referenced CPT code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that although both services typically involve the same intra-service time, the reference code describes a slightly more intense service to perform. **The RUC recommends a work RVU of 9.80 for CPT code 37280.**

37281 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 47543 *Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple* (work RVU= 3.00, intra-service and total time= 30) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of time and the same overall amount of physician work. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (recommended work RVU= 4.75, intra-service time= 45, total time= 45) to ensure appropriate relativity within the family and noted that 37281 typically takes 15 minutes less time and, unlike 37289, does not include the work of an atherectomy. The RUC also referenced CPT code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, intra-service and total time= 30)**. The RUC recommends a work RVU of 3.00 for CPT code 37281.**

37282 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel***

The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 92943 *Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel* (work RVU= 12.31, intra-service time= 92 minutes, total time= 151 minutes) appropriately accounts for the work required to perform this service. Both

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services typically involve a similar amount of intra-service time and the same overall amount of physician work. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 100 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37290 (recommended work RVU= 17.00, intra-service time= 150, total time= 218) to ensure appropriate relativity within the family and determined that the 37282 involves munch less time, and unlike 37290, does not also include an atherectomy. The RUC also compared the survey code to CPT code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that the surveyed code involves 10 more minutes of intra-service time, 27 more minutes of total time and a higher level of physician work intensity. **The RUC recommends a work RVU of 12.31 for CPT code 37282.**

37283 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 4.26 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 45 minutes of intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (recommended work RVU= 4.75, intra-service time= 45, total time= 45) to ensure appropriate relativity within the family and determined that, unlike 37289, 37283 does not include the work of performing an atherectomy. The RUC also compared the survey code to CPT code 67340 *Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)* (work RVU= 5.00, intra-service and total time= 45) and noted that both services typically involve the same amount of time, though the reference code is somewhat more intense to perform. **The RUC recommends a work RVU of 4.26 for CPT code 37283.**

37284 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 10.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 30 minutes pre-

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service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 100 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37288 (recommended work RVU= 13.50, intra-service time= 120, total time= 188) to ensure appropriate relativity within the family and determined that 37284 typically involves 20 minutes less time and involves a less intense treatment modality (stent placement with angioplasty, when performed versus atherectomy with angioplasty, when performed). The RUC also compared the survey code to CPT code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that although the surveyed code involves somewhat more time, it is a somewhat less intense service to perform. **The RUC recommends a work RVU of 10.00 for CPT code 37284.**

37285 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 35686 *Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)* (work RVU= 3.34, intra-service and total time= 35) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of time and the same overall amount of physician work. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 35 minutes of intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (work RVU= 4.75, intra-service time= 45, total time= 45) to ensure appropriate relativity within the family and determined that 37285 involves 10 minutes less time and a less intense treatment modality. The RUC also referenced CPT code 37247 *Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 3.50, 30 minutes intra-service and total time) and determined that both codes have similar work RVU's and times supporting the relativity of the recommendation. **The RUC recommends a work RVU of 3.34 for CPT code 37285.**

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37286 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 49594 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated* (work RVU= 13.46, intra-service time= 120, total time= 225) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of intra-service time and the same overall amount of physician work. The surveyed code is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee.

The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37290 (recommended work RVU= 17.00, intra-service time= 150, total time= 218) to ensure appropriate relativity within the family and noted that the 37286 typically involves 30 minutes less time and a less intense treatment modality (stent placement with angioplasty, when performed versus atherectomy with angioplasty, when performed). **The RUC recommends a work RVU of 13.46 for CPT code 37286.**

37287 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 5.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 50 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (recommended work RVU= 4.75, intra-service time= 45, total time= 45) to ensure appropriate relativity within the family and determined that both services have appropriate relativity as 37287 typically involves 5 more minutes of intra-service and total time. The RUC also referenced CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU= 7.00, intra-service and total time= 60), which involves 10 more minutes of time than the surveyed code. **The RUC recommends a work RVU of 5.00 for CPT code 37287.**

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37288 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 13.50 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee.
The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU= 15.00, intra-service time= 100, total time= 241) and determined that although the surveyed code typically involves 20 more minutes of intra-service time, the reference code involves more total time. The RUC also compared the survey code to second key reference code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that the surveyed code involves much more intra-service and total time and has appropriate relativity with this reference code. **The RUC recommends a work RVU of 13.50 for CPT code 37288.**

37289 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 4.75 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 45 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU= 6.50, intra-service and total time= 60) and noted that the

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reference code involves 15 more minutes of time. The RUC also compared the survey code to second key reference code 37186 *Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)* (work RVU= 4.92, intra-service and total time= 60) and noted that this reference code also involves 15 more minutes of time, though is a less intense service to perform than the surveyed code. **The RUC recommends a work RVU of 4.75 for CPT code 37289.**

37290 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 17.00 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee.

The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 150 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU= 15.00, intra-service time= 100, total time= 241) and noted that the surveyed code involves 50 more minutes of intra-service time, less total time, and is more intense to perform. The RUC also referenced CPT code 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium…* (work RVU= 15.00, intra-service time of 120 minutes, total time of 199 minutes) and noted that the surveyed code involves 30 more minutes of intra-service time and 19 more minutes of total time. **The RUC recommends a work RVU of 17.00 for CPT code 37290.**

37291 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device*

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selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure) (work RVU= 6.50, intra-service and total time of 60 minutes) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of intra-service and total time and the same overall amount of physician work. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 60 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (recommended work RVU= 4.75, intra-service time= 45, total time= 45) to ensure appropriate relativity within the family and determined that 37291 typically involves 15 more minutes of time and involves a complex lesion (instead of a straightforward lesion) for the same treatment modality. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU= 7.00, intra-service and total time= 60) and noted that both services involve the same amount of time, though the reference code is somewhat more intense. The RUC also referenced CPT code 96547 *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)* (work RVU=6.53, intra-service and total time of 60 minutes). **The RUC recommends a work RVU of 6.50 for CPT code 37291.**

37292 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel***

The RUC reviewed the survey results from 46 surgeons and determined that the median work RVU of 15.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC noted that using the median survey value is warranted for this code as it includes the work of stent placement and atherectomy and an angioplasty, when performed. A lower value would create a rank order anomaly with other services in the code family given the treatment modalities and the vascular territory.

The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 142 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37288 (recommended work RVU= 13.50, intra-service time= 120, total time= 188) to ensure appropriate relativity within the family and noted that 37292 typically involves 22 more minutes of time and a more intense treatment modality (stent placement with atherectomy and angioplasty, when performed versus atherectomy and angioplasty, when performed). The RUC also referenced CPT code 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from*

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coronary sinus or left atrium… (work RVU= 15.00, intra-service time of 120 minutes, total time of 199 minutes). **The RUC recommends a work RVU of 15.00 for CPT code 37292.**

37293 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 6.50 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 60 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (recommended work RVU= 4.75, intra-service and total time= 45) to ensure appropriate relativity within the family and noted that 37293 includes all of the work of 37289 and then also the placement of a stent. The RUC also referenced CPT code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU= 7.00, intra-service and total time= 60) and CPT code 96547 *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)* (work RVU=6.53, intra-service and total time of 60 minutes). **The RUC recommends a work RVU of 6.50 for CPT code 37293.**

37294 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel***
The RUC reviewed the survey results from 46 surgeons and determined that the median work RVU of 18.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC noted that using the median survey value is warranted for this code as it involves a complex lesion and includes the work of stent placement and atherectomy and an angioplasty, when performed. A lower value would create a rank order anomaly with other services in the code family given the treatment modalities and the vascular territory.

The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 170 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37290 (recommended work RVU= 17.00, intra-service time= 150, total time= 218) to ensure appropriate relativity within the family and noted that 37294 includes all of the work of 37290 and then also the placement of a stent. The RUC also referenced CPT code 49622 *Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of*

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mesh or other prosthesis, when performed; incarcerated or strangulated (work RVU= 17.06, intra-service time= 150 minutes, total time= 255 minutes) and noted that the surveyed code typically involves 20 more minutes of intra-service time. **The RUC recommends a work RVU of 18.00 for CPT code 37294.**

37295 ***Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 34833 *Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 8.16, intra-service and total time of 72 minutes) appropriately accounts for the work required to perform this service. Both services typically involve similar intra-service and total times and the same overall amount of physician work. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 75 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37289 (recommended work RVU= 4.75, intra-service and total time= 45) to ensure appropriate relativity within the family and determined that 37295 is appropriately valued higher as it typically involves 30 more minutes of intra-service and total time, requires a more intensive treatment modality (stent placement with atherectomy and angioplasty, when performed versus atherectomy with angioplasty, when performed) and describes a complex lesion. The RUC also compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU= 7.00, intra-service time= 60, total time= 60) and noted that the surveyed code typically involves 15 more minutes of time. **The RUC recommends a work RVU of 8.16 for CPT code 37295.**

Inframalleolar Vascular Territory (37296-37299)

37296 ***Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel***
The RUC reviewed the survey results from 113 surgeons and determined that the 25th percentile work RVU of 11.00 appropriately accounts for the physician work required to perform this service. This is one of the eleven survey codes that underwent a full standard RUC survey based on the custom survey methodology approved by the Research Subcommittee.

The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 100 minutes intra-service time, 30 minutes immediate post-service time.

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To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU= 15.00, intra-service time= 100, total time= 241) and noted that, although both services typically involve the same amount of intra-service time, the reference code involves more total time. The RUC also compared the survey code to second key reference code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU= 10.42, intra-service time= 90, total time= 141) and noted that the surveyed code involves 10 more minutes of intra-service time and 27 more minutes of total time. The RUC agreed that their recommended value would have appropriate relativity with these two reference codes. **The RUC recommends a work RVU of 11.00 for CPT code 37296.**

37297 ***Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 46 surgeons and determined that the 25th percentile work RVU of 4.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 40 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 44128 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU= 4.44, intra-service and total time= 40) and noted that both services typically involve the same amount of time, though the reference code is somewhat more intense to perform typically. The RUC also referenced CPT code 67340 *Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)* (work RVU= 5.00, intra-service time= 45, total time= 45) and noted that the surveyed code typically involves 5 minutes less time. **The RUC recommends a work RVU of 4.00 for CPT code 37297.**

37298 ***Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel***

The RUC reviewed the survey results from 46 surgeons and determined a direct work RVU crosswalk to CPT code 49621 *Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible* (work RVU= 13.70, intra-service= 120 minutes, total time= 220 minutes) appropriately accounts for the work required to perform this service. Both services typically involve the same amount of intra-service time and the same overall amount of physician work. This is one of the 35 survey codes that

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underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee.

The RUC recommends 30 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to core family code 37296 (recommended work RVU= 11.00, intra-service time= 100, total time= 168) to ensure appropriate relativity within the family and determined that 37298 typically involves 20 more minutes of intra-service time and total time, as well as a complex lesion. The RUC also compared the survey code to CPT code 93653 *Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium…* (work RVU= 15.00, intra-service time of 120 minutes, total time of 199 minutes) and noted that both services typically involve the same amount of intra-service time, though the reference code typically involves 11 more minutes of total time. **The RUC recommends a work RVU of 13.70 for CPT code 37298.**

37299 ***Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 surgeons and determined that the median work RVU of 5.00 appropriately accounts for the physician work required to perform this service. This is one of the 35 survey codes that underwent an abbreviated RUC survey based on the custom survey methodology approved by the Research Subcommittee. The RUC recommends 45 minutes intra-service and total time.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 44128 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU= 4.44, intra-service and total time= 40) and noted that the surveyed code typically involves 5 more minutes of time and is somewhat more intense to perform. The RUC also referenced CPT code 67340 *Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)* (work RVU= 5.00, intra-service and total time= 45) and noted that the surveyed code typically involves the same amount of time and the same level of physician work intensity. **The RUC recommends a work RVU of 5.00 for CPT code 37299.**

Practice Expense
The Practice Expense (PE) Subcommittee considered and approved compelling evidence based on changes in technique, changes in technology, significant shifts in site of service for the performance of these procedures and a change in population.

The PE Subcommittee reviewed the direct practice expense inputs and made a modification to remove 4 supply inputs to avoid overlapping with moderate sedation services that are separately reportable (and in SA044 *pack, moderate sedation*). The supplies removed were SC001 *angiocatheter 14g-24g*, SG037 *dressing, 4in x 4.75in (Tegaderm)*, SC018 *iv infusion set* and SA019 *kit, iv starter*. . The specialties

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noted that in general most lower extremity revascularization services are performed with moderate sedation a little more than half the time. The specialties also noted that all arterial access procedures have a minimum four hours post procedure recovery time as per standard national protocol. The first hour of post-procedure recovery/monitoring is now typically reported with separate moderate sedation codes and therefore did not include overlapping time for clinical labor or in their equipment minute recommendations. The specialties recommended and the PE Subcommittee concurred that 45 minutes of RN time should be allocated to CA022 *Monitor patient following procedure/service, multitasking 1:4* for the 2nd through 4th hour of recovery, and this time is not duplicative with the separately reported moderate sedation services codes. The Subcommittee confirmed that there is no overlap between the separately reported moderate sedation codes and the equipment minute recommendations.

The PE Subcommittee acknowledged the four existing and six new high-cost supply inputs as recommended by the specialty societies. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes.

High-Cost Supplies:

SD253	Atherectomy Device
SD254	covered stent (VIABAHN, Gore)
SD255	Reentry device (Frontier, Outback, Pioneer)
SD256	Embolic Protection Device Spider FX (EV3, documentation available)
NEW	drug eluting stent, tibial
NEW	Iliac IVL Catheter
NEW	FemPop IVL Catheter
NEW	Drug coated balloon
NEW	Drug eluting stent
NEW	Embolic protection for atherectomy

The high-cost supplies were discussed in detail. The presenters noted the difference between the existing embolic protection device (SD256) and the newly recommended "Ebolic protection for atherectomy" device. When performing atherectomy, proprietary wires are typically used which can accommodate rapid rotations of the devices. In most cases, the support wire represents a proprietary wire that is associated with each product but is best represented by SD173. In those cases, the Spider FX Embolic Protection device (SD256) cannot be used because it would otherwise shatter and fragment the wire. For this reason, a new product that can be used with the proprietary wires for various atherectomy devices is more appropriate (see Embolic protection device for atherectomy).

The presenters noted that base CPT codes 37263, 37265, 37271 and 37273 would typically require two drug-coated balloons, whereas their corresponding add-on codes (37264, 37266, 37272 and 37274) would typically only require one drug-coated balloon for each additional vessel. For the base codes, the surgeon is typically treating the superficial femoral artery and popliteal artery, which is considered one segment, and that segment is much longer than the common femoral artery or the profunda femoris. It is typical to have multifocal or long-segment disease in the superficial femoral artery and popliteal artery segment to where one drug-coated balloon, which can only be used once, will not be adequate to treat the whole area. It would be most common to report the add-on codes for the common femoral artery or the profunda femoral artery segment, which are short enough that the surgeon can treat them with one drug-coated balloon. If the surgeon is only performing a procedure on one vessel in this territory, it would typically be the longer superficial femoral artery and popliteal artery segment. The length of superficial femoral artery disease almost always extends from the origin of the superficial femoral artery down to the end of the superficial femoral artery, which is the adductor canal just above the knee. The presenters noted that in this vessel, it is most typical to have long-segment disease.

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The presenters noted that tibial segment complex codes 37286 and 37287 typically require two drug-eluding stents each, whereas tibial segment straightforward codes 37284 and 37285 only require one drug-eluding stent each. The length of the vessel is the same between a straightforward and a complex lesion for 37284-37287. The difference is that in tibial interventions the surgeons are typically working with stents that are as long as 38mm, which is still relatively short. In general, the surgeon would only use stents in areas where they feel they have to maintain the patency of the vessel. For a straightforward lesion, it is usually only needed in one location. Whereas for complex lesions (which are defined as occlusive disease), the occlusive disease is typically quite long. It is most typical to use 2 stents in the tibial segment for complex lesions and there are even edge cases where the surgeon could use 4 or 5 stents in the tibial segment. The longest stents are around 38mm whereas the tibial segment averages around 300mm.

Finally, the PE Subcommittee considered the request from the specialties to create a new supply pack for angiography services and agreed that an angio pack would facilitate the PE process and ensure consistency within the vascular/interventional procedures. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Creation of New Angio Supply Pack
The PE Subcommittee considered the request from the specialties to create a new pack for angiography services. As described in the PE SOR, the specialty societies are recommending the PE Subcommittee consider creating an angio pack with the following components:

Angio Pack Contents	**Supply Code**	**Corresponding Supply list components**	**Unit**	**Price**	**Quantity**	**Total: $ 68.26**
10 cc syringe	SC051	syringe 10-12ml	item	0.21	4	$ 0.84
Bowl, sterile	SJ079	basin, sterile 500cc	item	3.51	2	$ 7.02
gauze	SG055	gauze, sterile 4in x 4in	item	0.19	20	$ 3.80
marker, regular tip	SK075	skin marking pen, sterile (Skin Skribe)	item	1.62	1	$ 1.62
dome cover	SB008	drape, sterile, c-arm, fluoro	item	5.38	1	$ 5.38
blue towels	SB019	drape-towel, sterile 18in x 26in	item	0.47	4	$ 1.88
scalpel	SF007	blade, surgical (Bard-Parker)	item	0.68	1	$ 0.68
back table cover	SB014	drape, sterile, three-quarter sheet	item	3.46	1	$ 3.46
20cc syringe	SC053	syringe 20ml	item	0.83	4	$ 3.32
drape, femoral	SB009	drape, sterile, femoral	item	9.15	1	$ 9.15
medicine cup	SL157	cup, sterile, 8 oz	item	0.58	1	$ 0.58
label sheet	SL198	label, vial	item	0.02	9	$ 0.18
control syringe (lidocaine)	SC051	syringe 10-12ml	item	0.21	1	$ 0.21

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scissor	SA027	kit, scissors and clamp	kit	0.82	1	$ 0.82
surgical gowns x 2	SB028	gown, surgical, sterile	item	5.13	2	$ 10.26
18 G needle	SC027	needle, 18-19g, filter	item	0.21	1	$ 0.21
25 G needle	SC028	needle, 18-26g 1.5-3.5in, spinal	item	9.96	1	$ 9.96
needle counter	SD120	styrofoam block, high density (3in-12in-12in)	item	1.86	1	$ 1.86
towel clamps (plastic disposable)	SD208	towel clamp, plastic	item	0.76	4	$ 3.04
Guidewire bowl	SD171	guidewire bowl w-lid, sterile	Item	3.99	1	$ 3.99

The PE Subcommittee agrees that an angio pack would facilitate the PE process and ensure consistency within the vascular/interventional procedures. The RUC recommends the angio supply pack as proposed by the Practice Expense Subcommittee.

New Technology/New Services
The two intravascular lithotripsy (IVL) CPT codes 37262 and 37279 will be placed on the New Technology list to be reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions. CPT 37262 and 37279 describe a new treatment modality which was not previously captured in the existing code set. All other services in this code family were described by the legacy code set and are not considered new technology. It was noted that utilization assumptions will automatically be reviewed for all codes in the family once one year of claims data are available.

Endoscopic Sleeve Gastroplasty (Tab 7)
Matthew Brengman, MD (ASMBS), Bruce Cameron, MD (ACG), Seth Gross, MD (ASGE), Ketan Sheth, MD (SAGES), Shelby Sullivan, MD (ASGE)

In September 2024, the CPT Editorial Panel approved the addition of a new Category I code to report transoral gastric restrictive procedures through an endosurgical approach. The specialties surveyed Endoscopic Sleeve Gastroplasty (ESG) for the January 2025 RUC meeting.

43889 ***Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed***
The RUC reviewed the survey results from 107 gastroenterologists, bariatric surgeons, and gastrointestinal and endoscopic surgeons and concurred that the survey respondents overstated the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU = 13.50, 90 minutes intra-service time and 276 minutes total time) falls below the survey 25th percentile and appropriately accounts for the physician work involved in this service. The crosswalk code was surveyed in 2013 and has identical intra-service time as 43889 and similar total time and intensity.

The RUC recommends the following physician time components: 40 minutes pre-service evaluation, 3 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, and 43 minutes immediate post-service time, 0.5-99238 discharge visit and 3-99213

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office visits for 274 minutes total time, as supported by the survey. Pre-time package 4 was selected with adjustments to the evaluation and positioning times. For the post-operative office visits, the RUC recommends the survey median response of three level-3 office visits. Patients undergoing ESG typically have three follow-up-visits occurring at weeks 1, 5, and 12 post ESG. The RUC discussed the components of the post-op visits in detail and concurred with the recommendation.

The RUC discussed the CMS 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy as it relates to the post-service time for the surveyed code. CMS labels surgical services that are typically performed in the outpatient setting and require an overnight hospital stay of less than 24 hours as 23-hour stay outpatient services. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to bundle subsequent hospital visits (e.g., 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. Per the CMS policy, the intra-service time is reallocated from the same-day E/M code 99232 to the immediate post-service time of the outpatient service (adding 20 minutes of intra-service time from 99232). Though the median survey immediate post-service time was 23 minutes, the CMS 23-hour stay policy was applied resulting in 43 minutes. The RUC recommends post-service time package 9B and, following the CMS 23-hour policy, the E/M same day visit is not shown and instead, the intra-service time of 20 minutes has been added to the median survey post time of 23 minutes (total = 43 minutes).

To justify a work RVU of 13.50, the RUC compared CPT code 43889 to the top key reference service code 43771 *Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only* (work RVU = 20.79, 120 minutes intra-service time and 377 minutes total time) and noted that the intra-service time and total time is much greater than the surveyed code and the reference code is also much more intense, justifying the higher work value. The RUC also compared CPT code 43889 to the second key reference service code 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03, 60 minutes intra-service time and 201 minutes total time) and noted that the reference service has less intra-service and total time and is appropriately valued lower than 43889. The RUC noted that the crosswalk value is appropriately bracketed by the two key reference service codes.

For additional support, the RUC compared CPT code 43889 to MPC code 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time and 283 minutes total time) and noted that the surveyed code has identical intra-service time and slightly less total time. Mastectomy is an open surgical dissection that requires skill to ensure complete tissue removal and manage postoperative risks. ESG, on the other hand, requires advanced endoscopic techniques and surgery with an endoscope to avoid complications like gastric perforation or suture failure and massive or overt intraluminal or extraluminal hemorrhage. Thus, the comparison code is slightly more intense, justifying the higher work value. The RUC also offered CPT code 37218 *Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation* (work RVU = 14.75, 90 minutes intra-service time and 255 minutes total time) for comparison. Both services are minimally invasive procedures where 37218 requires vascular access, stent placement, and the use of advanced imaging for guidance. ESG requires endoscopic access and modification of stomach structure through suturing without image guidance. The RUC noted, similarly, that the surveyed code has identical intra-service time, yet the comparator code is more intense, justifying the higher work value. The RUC further compared 43889 to CPT code 50080 *Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade*

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ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones) (work RVU = 12.41, 90 minutes intra-service time and 244 minutes total time) and noted that the surveyed code has identical intra-service time, yet more total time. CPT code 50080 is performed to remove obstructions in the urinary tract, utilizing energy to fragment and remove. ESG is performed entirely endoscopically and is reliant on internal suturing with no external incisions. ESG is clinically more complex to perform and manage complications when compared to the more standardized and image-supported approaches of PCNL/lithotripsy, therefore 50080 is appropriately valued lower than 43889. The RUC noted that the crosswalk value is appropriately bracketed by these comparison codes.

The RUC concluded that CPT code 43889 should be valued based on a direct work RVU crosswalk to CPT code 36832, noting that both services involve an identical amount of intra-service time and similar total time, and agreed the crosswalk value below the survey 25th percentile is appropriate. **The RUC recommends a work RVU of 13.50 for CPT code 43889.**

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

New Technology
CPT code 43889 will be placed on the New Technology list and will be re-reviewed by the RUC in three years.

Irreversible Electroporation of Tumors (Tab 8)
Michael Booker, MD (ACR), Seth Cohen, MD (AUA), Minhaj Khaja, MD (SIR), Jonathan Kiechle, MD (AUA), Cindy Yuan, MD (ACR)

In September 2024, the CPT Editorial Panel approved the addition of two new Category I codes to report percutaneous irreversible electroporation ablation of one or more tumors in the liver and prostate respectively, and the revision of a Category III code to specify ablation in organs other than the liver or prostate.

47384 ***Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous***
The RUC reviewed the survey results from 36 radiologists and interventional radiologists and determined that the survey 25th percentile work RVU of 9.41 appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, and 30 minutes immediate post-service time for 190 minutes total time as supported by the survey. The RUC noted that surgical oncologists or hepatologists typically provide the patient's follow-up care.

The RUC recommends pre-service time package 4 (Facility, Difficult Patient/Difficult Procedure) with the following adjustments:

> Evaluation: Pre-service evaluation time of 40 minutes is recommended, which is 10 minutes less than the median survey time, but matches the package time. As a difficult patient, typically the patient has cirrhosis, portal hypertension, is not a surgical candidate and may have thrombocytopenia and coagulopathies, 40 minutes is appropriate to complete this work.

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Positioning: The median survey time of 15 minutes, which is 12 minutes more than the package time is recommended. This is warranted due to set up of monitoring devices, lines, tubes and anesthesia equipment within a CT room and ensuring that all devices attached to the patient are able to clear and slide in and out of the CT gantry to maintain sterility and procedural success.

Scrub, dress, and wait: The median survey time of 15 minutes, which is 5 minutes less than the package time and supported by the survey data is recommended.

To justify a work RVU of 9.41, the RUC compared the surveyed code to the top key reference service code 32994 *Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation* (work RVU = 9.03, 90 minutes intra-service time and 168 minutes total time) and noted that the intra-service time is identical, yet total time is slightly higher for the surveyed code, justifying a slightly higher value. Moreover, over 80% of the survey respondents who selected the first key reference service rated 47384 as overall more intense and complex relative to the reference code. The RUC also compared the surveyed code to the second key reference service code 20982 *Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency* (work RVU = 7.02, 80 minutes intra-service time and 148 minutes total time) and noted that the reference service has less intra-service and total time, thus, is appropriately valued less than 47384.

For additional support, the RUC compared CPT code 47384 to MPC code 36905 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty* (work RVU = 9.00, 75 minutes intra-service time and 126 minutes total time) and noted that the surveyed code has more intra-service time and is therefore appropriately valued higher than the comparator code. The RUC also compared 47384 to MPC code 36906 *Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit* (work RVU = 10.42, 90 minutes intra-service time and 141 minutes total time) and noted that the intra-service time is identical, yet the reference code is more intense and is therefore appropriately valued higher than the surveyed code. The RUC noted that the survey 25th percentile value is appropriately bracketed by the two MPC codes.

The RUC concluded that CPT code 47384 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 9.41 for CPT code 47384.**

55877 ***Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous***

The RUC reviewed the survey results from 33 urologists and concurred that the survey respondents overstated the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 15730 *Midface flap (ie, zygomaticofacial flap) with preservation*

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of vascular pedicle(s) (work RVU = 13.50, 90 minutes intra-service time and 255.5 minutes total time), which falls below the survey 25th percentile and has identical intra-service time, appropriately accounts for the physician work involved in this service. The RUC recommends 45 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 90 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge visit, and 1-99213 and 1-99214 office visits for 254 minutes total time as supported by the survey. The RUC noted that the urologist performing the procedure typically provides the patient's follow-up care.

CPT code 55877 is a complex procedure to focally ablate a prostate tumor. The probes must be carefully positioned to avoid damage to surrounding structures including the bladder, rectum, urethra, external urethral sphincter, and neurovascular bundles. Throughout the ablation procedure, the physician is carefully monitoring the electroporation process to ensure appropriate tissue destruction takes place. Given that the procedure is being done for cancer treatment, confirming adequate ablation is imperative throughout the treatment.

To justify a work RVU of 13.50, the RUC compared CPT code 55877 to the top key reference service code 55880 *Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance* (work RVU = 17.73, 180 minutes intra-service time and 373 minutes total time) and noted that the intra-service time of the key reference service is twice as much as the surveyed code, justifying the higher work value for the reference service. The RUC also compared CPT code 55877 to the second key reference service code 50250 *Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed* (work RVU = 22.22, 145 minutes intra-service time and 541 minutes total time) and noted that the reference service has more intra-service and total time and is appropriately valued higher than 55877.

For additional support, the RUC noted a strong comparison for CPT code 43889 with MPC code 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36, 90 minutes intra-service time and 248 minutes total time) which is a urology code with identical intra-service time and similar total time.

The RUC concluded that CPT code 55877 should be valued based on a direct work RVU crosswalk to MPC code 15730, noting that both services involve an identical amount of intra-service time and nearly identical total time, and agreed the crosswalk value below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 13.50 for CPT code 55877.**

Practice Expense
For CPT code 47384, the Practice Expense Subcommittee reviewed the direct practice expense inputs and acknowledged that the pre-service clinical activity time for 000- and 010-day global codes is presumed to be zero. The Subcommittee agreed with the specialties' argument that the pre-service time of setting up the procedure is equivalent to a 090-day global code and the site of service would be in the facility setting only. The PE Subcommittee made no modifications to the standard inputs and agreed with the specialties' use of the pre-service time package for "Comprehensive Use of Clinical Staff" in the facility for a 000-day global code. For CPT code 55877, the PE Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

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New Technology/New Services
CPT code 55877 will be placed on the New Technology list and will be re-reviewed by the RUC in three years. However, CPT code 47384, the procedure for irreversible electroporation of the liver, is not considered new technology.

Cystourethroscopy (Tab 9)
Seth Cohen, MD (AUA), Jonathan Kiechle, MD (AUA)

In September 2019, the CPT Editorial Panel created a new Category III code, 0619T, for reporting placement of a medication-coated balloon to deliver medication to the prostate following the completion of an anterior commissurotomy. In September 2024, a CPT code change application (CCA) was submitted to the CPT Editorial Panel to delete Category III code 0619T and create a new Category I code, CPT code 52443, to describe this procedure. CPT code 52443 was surveyed for the January 2025 RUC Meeting.

52443 ***Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed***
The RUC reviewed survey results from 47 urologists and recommends the survey 25th percentile work RVU of 3.62, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 30 minutes pre-service evaluation time, 8 minutes pre-service positioning time, 9 minutes scrub/dress/wait time, 30 minutes intra-service time and 15 minutes immediate post-service time, which equals 92 minutes of total time. The specialty society selected pre-service package time *3-FAC Straightforward Patient/Difficult Procedure* and post-service time package *8A IV Sedation/Simple Procedure*, which were modified to reflect pre-service and post-service time more accurately.

This cystourethroscopy code describes an endoscopic procedure for the management of benign prostatic enlargement that entails using both a non-medication-coated and a medication-coated balloon to open the prostatic urethra. The physician begins by performing a transrectal ultrasound to evaluate and measure the prostate and determine the appropriately sized drug-coated balloon for prostatic treatment. Following measurements, the cystoscope is introduced, and the initial non-medication coated balloon is introduced and appropriately placed under both direct cystoscopic and fluoroscopic visualization to confirm proper placement. . The initial balloon is then inflated to create an anterior commissurotomy to split the anterior prostate, separate the lateral lobes, and allow for drug delivery with the secondary balloon in this area that is split apart. The initial dilation balloon is removed, and the drug-coated double-lobed balloon of appropriate length is then placed again under both cystoscopic and fluoroscopic guidance. The initial dilation typically leads to significant bleeding, making appropriate placement of the medication-coated balloon challenging.

Avoiding damage to the external urethral sphincter and trigone of the bladder is important. Improper placement can cause urinary incontinence and urethral damage, necessitating prolonged catheter drainage leading to significant procedural intensity. The medication-coated balloon is left in place within the prostatic channel for one minute to allow hydration of the drug coating and is then inflated for at least five minutes to allow the drug to penetrate the interstitium of the prostate. After the drug delivery is complete, the cystoscope and catheter are withdrawn, and a catheter is placed into the bladder as the catheter balloon is filled. Overall, this procedure is relatively more intense than many other balloon dilation procedures.

To support the recommended work RVU of 3.62, the RUC compared the surveyed code to top key reference code 52334 *Cystourethroscopy with insertion of ureteral guide wire through kidney to*

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establish a percutaneous nephrostomy, retrograde (work RVU = 3.37, 30 minutes intra-service time, 75 minutes total time) and second key reference code 37248 *Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein* (work RVU = 6.00, 60 minutes intra-service time, 119 minutes total time). The RUC recognizes that the two key reference services bracket the survey 25th percentile work RVU and total time. The surveyed code has identical intra-service time compared to code 52334 and the physician work required has nearly identical intensity and complexity when compared to both key reference services.

For additional support, the RUC referenced CPT code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU = 4.17, 60 minutes intra-service time, 106 minutes total time), based on identical intra-service time. Moreover, CPT code 58558 has greater total time and slightly higher intensity than CPT code 52443, thus making it appropriate that it also has a higher work RVU. The RUC also referenced CPT code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU = 3.50, 30 minutes intra-service time, 79 minutes total time), which requires identical intra-service time and slightly less total time, which is appropriate considering the surveyed code has a slightly higher work RVU. **The RUC recommends a work RVU of 3.62 for CPT code 52443.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for CPT code 52443 and made a single modification to remove EL018 *room, mobile c-ARM* and include only ER031 *fluoroscopic system, mobile C-Arm*, not both equipment items. The portable c-ARM fluoroscopy system utilizes low-dose radiation and requires the operator to be shielded but not a shielded room, while the shielded room has a high-energy C-Arm fluoroscopy system that requires the entire room to be shielded. The specialty society agreed that a urology practice would be using the low-dose portable C-Arm fluoroscopy system, not the C-Arm fluoroscopy room, and agreed that EL018 should be removed. The PE Subcommittee also acknowledged that the pre-service clinical staff time for 000- and 10-day global codes is presumed to be zero and agreed with the specialty's use of the pre-service time package for "Use of Clinical Staff for Endoscopy".

The PE Subcommittee acknowledged the new high-cost supply input, *Optilume BPH Prostatic Dilation Kit*, as recommended for CPT code 52443. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT code 52443 will be placed on the New Technology list to be reviewed by the RUC in three years.

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Percutaneous Interlaminar Lumbar Decompression (Tab 10)
Trent Emerick, MD (ASRA), Damean Freas, DO (NANS), Gordon Morewood, MD (ASA), Richard Rosenquist, MD (ASA), Graham Wagner, MD (IPSIS), Esther Yoon, MD (AAPM&R)

At the September 2024 CPT Editorial Panel meeting two new Category I codes, 62330 and 62331, were created to report percutaneous interlaminar lumbar decompression with partial removal of the ligamentum flavum. These two new codes replace the existing Category III code, 0275T, to report this service. The code family was surveyed for the January 2025 RUC meeting.

62287 ***Decompression percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar***
The specialty societies noted that the utilization of CPT code 62287 has always been low and continues to decline, with only 100 claims in the 2023 Medicare data. Given the low volume of 62287, the code could not be surveyed and properly valued within the code family. **Therefore, the specialty societies will submit a CPT code change application (CCA) requesting the deletion of CPT code 62287 for the CPT 2026 cycle.**

62330 ***Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one interspace, lumbar***
The RUC reviewed the survey results from 106 anesthesiologists and pain medicine specialists and recommends a work RVU of 8.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 40 minutes of pre-service evaluation time, 10 minutes positioning time, 10 minutes scrub/dress/wait time, 45 minutes intra-service time, 15 minutes immediate post-service time, 0.5-99238, 3-99213, and 208 minutes total time. The RUC concurred that the 0.5-day discharge is appropriate given that this service is primarily performed in the facility setting.

It is important to note that for the initial interspace, all imaging guidance is included, and the procedure is performed on one side and then the contralateral side; this code describes a bilateral procedure.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 22869 *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level* (work RVU = 7.03, 45 minutes intra-service, 175 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 = 15.00, 90 minutes intra-service, 271 minutes total time). The surveyed code is performed directly within the vertebral canal, however, in comparison the interspinous spacer procedure (code 22869) is not. The work of code 22869 is performed between the spinous processes of vertebrae rather than in proximity to the spinal cord like the surveyed code. The proximity to the spinal cord and vertebral canal increases the intensity and complexity of the surveyed code given that there are additional risks. This is due to the ligamentum flavum's intimate position relative to the spinal cord, nerve roots, and subarachnoid space. The space between spinous processes, as described by code 22869, is generally more removed from sensitive neurological tissues. Reference code 22867 describes the insert of an interspinous spacer between the spinous processes of vertebrae in the spine, however, different from code 22869 the procedure includes an open decompression. A procedure with an open decompression

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typically takes more time compared to a procedure without. The surveyed code does not include open decompression and has the same intra-service time as reference code 22869, albeit a higher total time supported the RUC recommended work RVU.

For additional support, the RUC reference MPC code 21556 *Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 7.66, 60 minutes intra-service, and 234 minutes total time) and 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, 45 minutes intra-service, and 161 minutes total time). The surveyed code work RVU is appropriately bracketed by the MPC codes. **The RUC recommends a work RVU of 8.00 for CPT code 62330.**

62331 ***Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 105 anesthesiologists and pain medicine specialists and recommends a work RVU of 4.25 based on a direct crosswalk to CPT code 60661 *Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, including imaging guidance, radiofrequency (List separately in addition to code for primary procedure)* (work RVU = 4.25, 45 minutes intra-service and total time), which maintains relativity within the family for this code. The RUC recommends 43 minutes of intra-service and total time for this add-on code.

It is important to note that for the add-on service, the initial interspace is complete, and then a new incision is made for an additional interspace. For the additional interspace, all imaging guidance is done again, and the procedure is performed on one side and then the contralateral side; this code describes a bilateral procedure. It is typical for only one additional interspace to be performed.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 22634 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 7.96, 65 minutes intra-service and total time) and 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service and total time). Reference code 22634 describes the work to treat each additional interspace during spinal fusion surgery using a posterolateral technique with a posterior interbody technique. Code 22634 is a procedure that involves the vertebral canal similar to the surveyed code. Survey respondents who selected 22643 as their key reference indicated that the surveyed code was identical (42%) or more intense/complex (26%) overall when compared to reference code 22643. Survey respondents who selected 22552 as their key reference indicated that the surveyed code was identical (42%) or more intense/complex (19%) when compared to the second reference code 22552. The surveyed code recommended work RVU is appropriately relative to the key reference services.

For additional support, the RUC reference MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and 22632 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 5.22, 60 minutes intra-service and total time). The surveyed code work RVU is appropriately bracketed by the MPC codes. **The RUC recommends a work RVU of 4.25 for CPT code 62331.**

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

New Technology
CPT codes 62330 and 62331 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years.

Laminotomy – Repair of Disc Defect (Tab 11)
Anthony DiGiorgio, MD (AANS), Hussein Elkousy, MD (AAOS), Clemens Schirmer, MD (CNS), Karin Swartz, MD (NASS)

At the September 2024 CPT Editorial Panel meeting, one new Category I add-on code was created to report repair of an annular defect by implantation of a bone anchored annular closure device after a laminotomy (hemilaminectomy) with decompression was performed. The new add-on code was surveyed for the January 2025 RUC meeting.

Code Family
The specialty societies indicated that CPT codes 63020, 63030, 63035, 63040, 63042, 63043, and 63044 are not a code family. First, code 63020 is for laminotomy with decompression for a cervical interspace and new code 63032 is for a lumbar interspace. Second, codes 63040-63044 are for re-exploration laminotomy with decompression and new code 63032 cannot be reported for re-exploration procedures. Further, the new add-on code 63032 can only be reported with primary code 63030 and only for a single interspace. Add-on code 63035 can also be reported with 63030 if an additional interspace laminotomy with decompression is performed, however, code 63032 cannot be reported for an additional level. Therefore, no other codes have had a change in physician work or practice expense as a result of the establishment of this new add-on code. **The RUC agreed that codes 63020, 63040, 63042, 63043, and 63044 do not need to be reviewed with 63032.**

63030 ***Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar***
63035 ***Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)***
The new code, 63032, is only to be reported with CPT codes 63030. Although code 63035 can also be reported with 63030, it would be for an additional interspace and not related to the new code 63032 which cannot be reported for an additional interspace as instructed in the parenthetical to report 63032 only once per operative session. In addition, the specialties stated that 63030 and 63035 were surveyed in 2022 and the work for these procedures is unchanged and distinct from the work of the new code. **The RUC agreed with the specialty societies and recommends affirmation of the current work RVU of 12.00 for CPT code 63030 and 3.86 for CPT code 63035.**

63032 ***Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 90 spine surgeons and recommends a work RVU of 2.50 based on a direct crosswalk to CPT code 33370 *Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for*

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primary procedure) (work RVU =2.50, 20 minutes intra-service and total time), which maintains relativity within the family for this code. The RUC recommends 21 minutes intra-service time and total time.

The purpose of this procedure is to close an annular defect in the outer portion of the intervertebral disc after a discectomy. This helps seal the annulus to prevent the leakage of disc material (nucleus pulposus) and recurrence of a herniation. The primary objective is to preserve the disc's natural function by preventing fluid and nucleus pulposus leakage and reducing the likelihood of re-herniation.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 22853 *Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)* (work RVU = 4.25, 45 minutes intra-service and total time) and second key reference code 22868 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)* (work RVU = 4.00, 45 minutes intra-service and total time). Both reference codes involve the placement of a device similar to the surveyed code, however, each procedure provides different approaches for treating intravertebral disc degeneration or spinal instability. Reference code 22853 is to provide scaffolding for bone grafting to restore disc height and alignment after a spinal fusion procedure allowing bone growth to fuse two vertebrae over time. Reference code 22853 is less intense and complex to perform when compared to the surveyed code since the procedure is not intended to preserve the disc's natural function. Reference code 22868 is similar to the surveyed code in that the implant placement is meant to improve functional outcomes for patients with certain types of spinal conditions while avoiding the need for a more invasive fusion procedure. However, reference code 22868 is not an add-on code for the same level and space as the primary procedure, but instead is reported for an additional level. This includes exposure and closure of the additional level which is generally considered less intense work than measuring and precise placement of the device itself. Therefore, the intensity/complexity of reference 22868 is less than the surveyed code.

For additional support, the RUC referenced MPC codes 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09, 15 minutes intra-service and total time) and 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time). The surveyed code work RVU is appropriately bracketed by the MPC codes. **The RUC recommends a work RVU of 2.50 for CPT code 63032.**

Practice Expense
The RUC recommends no direct practice expense inputs as CPT code 63032 is a facility only add-on service.

New Technology
CPT code 63032 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years.

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Baroreflex Activation Therapy (Tab 12)
Matthew Sideman, MD (SVS), David Slotwiner, MD (HRS), Jonathan Thompson, MD (SVS), Ed Tuohy, MD (ACC), Richard Wright, MD (ACC)

Baroreflex activation therapy (BAT) treats heart failure symptoms and resistant hypertension by electrically stimulating carotid baroreceptors within the carotid artery. This triggers the autonomic nervous system to regulate heart, kidney and vascular function through both sympathetic and parasympathetic pathways, reducing the heart's workload and helping it pump efficiently to relieve the often-debilitating symptoms of heart failure. The BAT modulation system received FDA approval in August 2019, and the CPT Editorial Panel approved conversion from a Category III code set to a Category I code set at the September 2024 CPT Panel meeting. This code family describes the implantation, replacement, revision, removal and interrogation/programming of a BAT modulation system and was surveyed for the January 2025 RUC meeting. The specialties initially surveyed using both a targeted sample from a vendor list and a random sample of the specialty societies' membership. Ultimately, the entire specialty society membership was surveyed.

64654 ***Initial open implantation of baroreflex activation therapy (BAT) modulation system, including lead placement onto the carotid sinus, lead tunnelling, connection to a pulse generator placed in a distant subcutaneous pocket (ie, total system), and intraoperative interrogation and programming***
The RUC reviewed survey results from 33 vascular surgeons and recommends the survey 25th percentile work RVU of 11.00, which appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 50 minutes immediate post-service time, 0.5-99238 and 1-99213 visit, which equals 252 minutes of total time.

The specialty society selected pre-service package time *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc* The selected time packages were modified to more accurately reflect pre-service and post-service time. The RUC agreed that a level three post-op visit (99213) is required to assess all incisions, perform wound care, perform a neurologic assessment and coordinate care for these medically labile patients. Moreover, the survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty society added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of this procedure, increasing it from 30 minutes to 50 minutes. The RUC agreed this was an appropriate allocation of post-service time considering the conventions of this policy.

The most complex part of this procedure involves dissecting around the carotid bulb. These patients have atherosclerotic risk factors, increasing their likelihood of concomitant carotid disease. Meticulous and careful dissection is required to minimize the risk of plaque embolization. Stroke is a real possibility, particularly with these patients who already have an elevated risk of stroke based on their co-morbidities. Additionally, the vagus nerve, hypoglossal nerve, and occasionally a recurrent laryngeal nerve must be identified and preserved to avoid significant complications. Finally, sutures are placed into the adventitia and outer media of the arterial wall to ensure the leads are secured. A suture too deep could cause hematoma and even a dissection; a suture too superficial could result in lead disruption and failure of the implant.

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To support the recommended work RVU of 11.00, the RUC compared the surveyed code to top key reference code 64582 *Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array* (work RVU = 14.00, 140 minutes intra-service time, 294 minutes total time) and second key reference code 64568 *Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* (work RVU = 9.00, 90 minutes intra-service time, 275 minutes total time). The RUC recognized that the surveyed code is appropriately compared to the two key reference services in terms of intra-service and total time, as well as relative intensity and complexity. The second top key reference service CPT code 64568 has identical intra-service time compared to the surveyed code time, but the surveyed code requires significantly higher intensity for the physician to perform. Notably, the two key reference services chosen by survey respondents bracket the survey 25th percentile work RVU.

For additional support, the RUC referenced MPC code 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time, 283 minutes total time), noting that it is a strong comparator based on it having identical intra-service time as the surveyed code. Moreover, CPT code 19303 requires more total time and has a greater intensity to perform for the physician than CPT 64654, thus making it appropriate that code 64654 also has a higher work RVU. **The RUC recommends a work RVU of 11.00 for CPT code 64654.**

64655 ***Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; lead only***
The RUC reviewed survey results from 21 vascular surgeons and noted that the required minimum number of survey responses was not achieved. The RUC recommends the survey 25th percentile work RVU of 11.30, which accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238 and 1-99213 visit, which equals 242 minutes of total time.

The specialty society selected pre-service package time *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc* The selected time packages were modified to more accurately reflect pre-service and post-service time. The RUC agreed that a level three post-op visit (99213) is required to assess all incisions, perform wound care, perform a neurologic assessment and coordinate care for these medically labile patients. Moreover, the survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty society added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of this procedure, increasing it from 20 minutes to 40 minutes. The RUC agreed this was an appropriate allocation of post-service time considering the conventions of this policy.

The most complex part of this procedure involves dissecting around the carotid bulb. This will be a redo field with scar tissue and is a greater risk for vessel wall injury and nerve injury. Meticulous and careful dissection is required to minimize the risk of plaque embolization. Tissue planes are more challenging given scar tissue formation. Stroke is a real possibility, particularly for these patients who typically already have an elevated risk of stroke based on their co-morbidities. Additionally, the vagus nerve, hypoglossal nerve, and occasionally a recurrent laryngeal nerve must be identified and preserved to avoid significant complications. In scared operative planes, this is even more challenging. Finally, sutures are placed into the adventitia and outer media of the arterial wall to ensure the leads are secured. In re-operative fields, the vessel wall can be stripped of the adventitia creating a challenge when securing the leads.

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To support the recommended work RVU, the RUC compared the surveyed code to key reference code 64569 *Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator* (work RVU = 11.00, 120 minutes intra-service time, 312 minutes total time) and second key reference code 64583 *Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator* (work RVU = 14.50, 150 minutes intra-service time, 309 minutes total time). The RUC recognized that the surveyed code is appropriately compared to the two key reference services and maintains relativity within the code family. The surveyed code requires less intra-service and total time but requires significantly higher intensity for the physician to perform. The RUC noted that the overall time for BAT revision in CPT code 64655 compared to the implantation of CPT code 64654 is comparable to and consistent with the intensity differences between similar procedures that involve implantation versus revision of epidural and spinal cord implants. As is the case with CPT code 64655, the overall physician work and intensity involved with the revision of these types of implants is nearly the same or slightly higher than that of the original implant. The RUC agreed that the relative value between CPT codes 64654 and 64655 is appropriate based on magnitude estimation. The specialty society mentioned that most vascular surgeons have minimal experience with generator replacement or revision compared to other specialties. The physician work involved with this service is related to troubleshooting connections and ensuring a functioning device, which is different from a simple battery exchange common in most electrocardiology procedures. Given the technical nuance necessary for performing this procedure, in addition to the high-risk nature of the typical patient, the RUC agreed that the surveyed code requires greater intensity than the survey comparator services.

For additional support, the RUC referenced MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time, 283 minutes total time) and 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 7.80, 60 minutes intra-service time, 233.5 minutes total time), noting that these two services bracket the survey 25th percentile work RVU, total time and intensity despite both requiring intra-service time. **The RUC recommends a work RVU of 11.30 for CPT code 64655.**

64656 *Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; pulse generator only*

The RUC reviewed survey results from 22 vascular surgeons and noted that the required minimum number of survey responses was not achieved.

The RUC recommends the survey 25th percentile work RVU of 8.01, which accounts for the physician work required to perform this service. The RUC recommends 18 minutes pre-service evaluation time, 1 minute pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 71 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238 and 1-99213 visit, which equals 187 minutes of total time.

The specialty society selected pre-service package time *2-FACE Diff Pat/Straightfor Proc(no sedation/anes)* and post-service package *8A IV Sedation/Simple Procedure*. The selected time packages were modified to more accurately reflect pre-service and post-service time. The RUC agreed that a level three post-op visit (99213) is required to assess all incisions, perform wound care, perform a neurologic assessment and coordinate care for these medically labile patients. Moreover, the survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty society added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of this procedure, increasing it from 20

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minutes to 40 minutes. The RUC agreed this was an appropriate allocation of post-service time considering the conventions of this policy.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 64583 *Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator* (work RVU = 14.50, 150 minutes intra-service time, 309 minutes total time) and second key reference code 64569 *Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator* (work RVU = 11.00, 120 minutes intra-service time, 312 minutes total time). The RUC recognizes that the surveyed code is appropriately compared to the two key reference services and maintains relativity within the code family. The surveyed code requires significantly less intra-service and total time but has a higher intensity for the physician and is a greater risk to perform. The specialty society mentioned that most vascular surgeons have minimal experience with generator replacement or revision compared to other specialties. The physician work involved with this service is related to troubleshooting connections and ensuring a functioning device, which is different from a simple battery exchange common in most electrocardiology procedures. The RUC agreed that the technical nuance and skill necessary for performing this procedure, in addition to the high-risk nature of the typical patient, justifies the recommended intra-service time for the surveyed code.

For additional support, the RUC referenced CPT code 33725 *Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed* (work RVU = 8.59, 75 minutes intra-service time, 188 minutes total time), noting that it is a strong comparator based on it similar intra-service and total time as the surveyed code. Moreover, CPT code 33275 requires a greater intensity to perform for the physician than CPT 64656, thus making it appropriate that it also has a higher work RVU. **The RUC recommends a work RVU of 8.01 for CPT code 64656.**

64657 ***Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator***

The RUC reviewed survey results from 22 vascular surgeons and noted that the required minimum number of survey responses was not achieved. The RUC recommends the survey 25th percentile work RVU of 12.13, which accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 115 minutes intra-service time, 50 minutes immediate post-service time, 0.5-99238 and 1-99213 visit, which equals 277 minutes of total time.

The specialty society selected pre-service package time *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc* The selected time packages were modified to more accurately reflect pre-service and post-service time. The RUC agreed that a level three post-op visit (99213) is required to assess all incisions, perform wound care, perform a neurologic assessment and coordinate care for these medically labile patients. Moreover, the survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty society added 30 minutes of intra-service time from CPT code 99233 to the immediate post-service time of this procedure, increasing it from 20 minutes to 50 minutes. The RUC agreed this was an appropriate allocation of post-service time considering the conventions of this policy.

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This procedure is the most complicated procedure with regard to time and intensity in this code family. The typical patient has a complete explant of the lead and generator for infection. The system may be functioning properly, and the explant may have intra-operative complications including cardiovascular instability from sympathetic/parasympathetic dysregulation and/or a Systemic Inflammatory Response Syndrome (SIRS)/Sepsis response in the setting of infection, which is typical. Like the other revision codes in this code set, this procedure is always in non-virgin tissue planes and scar tissue can increase the risk of vessel damage and stroke. Additionally, infection can make the tissue planes inflamed and difficult to determine. Nerve identification can be challenging. Patients are at risk for vagus, hypoglossal, or recurrent laryngeal nerve injury. All implants must be removed in their entirety and wound care is performed. Incisions may not be closed, depending on the clinical situation.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 64584 *Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array* (work RVU = 12.00, 120 minutes intra-service time, 275 minutes total time) and second key reference code 64570 *Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* (work RVU = 9.10, 90 minutes intra-service time, 259 minutes total time). The RUC recognizes that the surveyed code is appropriately compared to the two key reference services in terms of intra-service and total time, as well as relative intensity and complexity. The top key reference service CPT code 64584 has nearly identical intra-service and total time, but the surveyed code requires a slightly higher intensity for the physician to perform. The surveyed code is more intense than the top key reference code 64584, removal of hypoglossal nerve neurostimulator array, as removal of this device for the typical patient for 64584 is not performed due to infection.

For additional support, the RUC referenced CPT codes 64584 *Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array* (work RVU = 12.00, 120 minutes intra-service time, 275 minutes total time) and 64581 *Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)* (work RVU = 12.20, 120 minutes intra-service time, 269 minutes total time), noting that both codes are strong comparators based on similar intra-service and total time to the surveyed code. While CPT code 64657 has slightly less intra-service time, it requires greater intensity for the physician to perform, as well as slightly more total time. **The RUC recommends a work RVU of 12.13 for CPT code 64657.**

64658 ***Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator; lead only***

The RUC reviewed survey results from 20 vascular surgeons and noted that the required minimum number of survey responses was not achieved. recommends the survey 25th percentile work RVU of 8.95, which accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238 and 1-99213 visit, which equals 242 minutes of total time.

The specialty society selected pre-service package time *4-FAC Difficult Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc* The selected time packages were modified to more accurately reflect pre-service and post-service time. The RUC agreed that a level three post-op visit (99213) is required to assess all incisions, perform wound care, perform a neurologic assessment and coordinate care for these medically labile patients. Moreover, the survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that that a 23-hour stay (less than

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24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty society added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of this procedure, increasing it from 20 minutes to 40 minutes. The RUC agreed this was an appropriate allocation of post-service time considering the conventions of this policy.

Similar to 64657, this procedure is typically performed in the setting of infection. Similar to the other revision codes in this code set, this procedure is always in non-virgin tissue planes and scar tissue can increase the risk of vessel damage and stroke. Additionally, infection can make the tissue planes inflamed difficult to determine. Nerve identification can be challenging. Patients are at risk for vagus, hypoglossal, or recurrent laryngeal nerve injury. All implants must be removed in their entirety and wound care is performed. Incisions may not be closed, depending on the clinical situation.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 64584 *Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array* (work RVU = 12.00, 120 minutes intra-service time, 275 minutes total time) and second key reference code 64570 *Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* (work RVU = 9.10, 90 minutes intra-service time, 259 minutes total time). The RUC recognizes that the surveyed code is appropriately compared to the two key reference services in terms of intra-service and total time, as well as relative intensity and complexity. The surveyed code is more intense than in 64584, removal of hypoglossal nerve neurostimulator array, as removal of this device for the typical patient for 64584 is not performed due to infection. The second key reference service CPT code 64570 has identical intra-service and less total time overall; thus, the surveyed code is valued slightly less despite it requiring slightly higher intensity for the physician to perform. The specialty society mentioned that most vascular surgeons have minimal experience with generator replacement or revision compared to other specialties.

For additional support, the RUC referenced MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time, 283 minutes total time) and 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 7.80, 60 minutes intra-service time, 233.5 minutes total time), noting that these two services bracket the survey 25th percentile work RVU, total time and overall intensity despite both requiring less intra-service time. **The RUC recommends a work RVU of 8.95 for CPT code 64658.**

64659 ***Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator; pulse generator only***
The RUC reviewed survey results from 20 vascular surgeons and noted that the required minimum number of survey responses was not achieved. The RUC recommends the survey 25th percentile work RVU of 8.23, which accounts for the physician work required to perform this service. The RUC recommends 18 minutes pre-service evaluation time, 1 minute pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 76 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238 and 1-99213 visit, which equals 192 minutes of total time.

The specialty society selected pre-service package time *2-FACE Diff Pat/Straightfor Proc(no sedation/anes)* and post-service package *8A IV Sedation/Simple Procedure*. The selected time packages were modified to more accurately reflect pre-service and post-service time. The RUC agreed that a level three post-op visit (99213) is required to assess all incisions, perform wound care, perform a neurologic assessment and coordinate care for these medically labile patients. Moreover, the survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24

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hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty society added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of this procedure, increasing it from 20 minutes to 40 minutes. The RUC agreed this was an appropriate allocation of post-service time considering the conventions of this policy.

Similar to 64657 and 64658, this procedure is typically performed in the setting of infection. Given the infectious nature, the additional time relative to 64656 is likely related to dealing with the infection including providing intra-operative wound care. The system may be functioning properly, and the explant may have intra-operative complications including cardiovascular instability from sympathetic/parasympathetic dysregulation and/or a Systemic Inflammatory Response Syndrome (SIRS)/Sepsis response.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 64584 *Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array* (work RVU = 12.00, 120 minutes intra-service time, 275 minutes total time) and second key reference code 33262 *Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system* (work RVU = 5.81, 60 minutes intra-service time, 150 minutes total time). The RUC recognized that the surveyed code is appropriately compared to the two key reference services and maintains relativity within the code family. Compared to the top key reference code 64584, the surveyed code requires significantly less intra-service and total time but requires greater intensity for the physician to perform. Compared to the second key reference code 33262, the surveyed code requires more intra-service and total time, as well as greater intensity to perform. The surveyed code 25th percentile is appropriately bracketed by the two reference codes based on work RVU.

For additional support, the RUC referenced MPC codes 19303 *Mastectomy, simple, complete* (work RVU = 15.00, 90 minutes intra-service time, 283 minutes total time) and 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 7.80, 60 minutes intra-service time, 233.5 minutes total time), noting that these two services bracket the survey 25th percentile work RVU, total time and intensity despite both requiring intra-service time. **The RUC recommends a work RVU of 8.23 for CPT code 64659.**

93145 ***Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); without programming***
The RUC reviewed survey results from 27 cardiologists and cardiac electrophysiologists and noted that the required minimum number of survey responses was not achieved. The RUC recommends the survey 25th percentile work RVU of 0.79, which accounts for the physician work required to perform this service. The RUC recommends 7 minutes pre-service evaluation time, 10 minutes intra-service time and 5 minutes immediate post-service time, which equals 22 minutes of total time.

The physician work involved with this service describes the reporting of the interrogation of the BAT modulation system to monitor device diagnostics and programmed therapy values with interpretation and report without programming.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 93279 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with*

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analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber (work RVU = 0.65, 10 minutes intra-service time, 22 minutes total time) and second key reference code 93281 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system* (work RVU = 0.85, 15 minutes intra-service time, 32 minutes total time). The RUC recognizes that the surveyed code is appropriately compared to the two key reference services in terms of intra-service and total time, as well as relative intensity and complexity. The top key reference service CPT code 93279 has identical intra-service time and nearly identical total time as the surveyed code. Notably, the surveyed code has a higher estimated intensity and complexity measure than the two key reference services, which is appropriate based on these codes' relative values.

For additional support, the RUC referenced MPC codes 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time, 26 minutes total time) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93, 15 minutes intra-service time, 20 minutes total time). The RUC recognized that the survey 25th percentile work RVU is bracketed by the two MPC codes in terms of work RVU and intensity. **The RUC recommends a work RVU of 0.79 for CPT code 93145.**

93146 *Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming, including optimization of tolerated therapeutic level setting*

The RUC reviewed survey results from 28 cardiologists and cardiac electrophysiologists and noted that the required minimum number of survey responses was not achieved. The RUC recommends the survey 25th percentile work RVU of 0.90, which accounts for the physician work required to perform this service. The RUC recommends 8 minutes pre-service evaluation time, 15 minutes intra-service time and 7 minutes immediate post-service time, which equals 30 minutes of total time.

The physician work involved with this service describes the reporting of the interrogation of the BAT modulation system to monitor device diagnostics and programmed therapy values with interpretation, report, and programming. Unlike CPT code 93145, this also includes optimization of tolerated therapeutic level setting.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 93281 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system* (work RVU = 0.85, 15 minutes intra-service time, 32 minutes total time) and second key reference code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.92, 30 minutes intra-service time, 47 minutes total time). The RUC recognizes that the surveyed code is appropriately compared to

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the two key reference services in terms of intra-service and total time, as well as relative intensity and complexity. The top key reference service CPT code 93281 has identical intra-service time compared to the surveyed code time, but the surveyed code is slightly more intense and complex to perform Notably, the two key reference services bracket the survey 25th percentile.

For additional support, the RUC referenced MPC codes 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time, 26 minutes total time) and 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 15 minutes intra-service time, 26 minutes total time) noting that these two services bracket the survey 25th percentile work RVU, total time and intensity. **The RUC recommends a work RVU of 0.90 for CPT code 93146.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. For CPT code 93146, when considering the minutes included in CA021 *Perform procedure/service---NOT directly related to physician work time*, the PE Subcommittee discussed whether a six-minute walk test is included; it is not as CPT code 94618 *Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed* can be reported separately. The PE Subcommittee recommends that the specialty societies request a CPT parenthetical edit to clarify this point. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT codes 64654, 64655, 64656, 64657, 64658, 64659, 93145 and 93146 will be placed on the New Technology list to be reviewed by the RUC in three years.

RUC Database Flag
The RUC recommends that this entire code family be flagged for "Do Not Use to Validate Physician Work-Low Survey Response" in the RUC database. This entire code family after three years of data for this flag and new technology.

<u>Percutaneous Electrical Nerve Field Stimulation (Tab 13)</u>
Suzanne Berman, MD (AAP), Bruce Cameron, MD (ACG), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Katja Karrento, MD (AGA), Jonathan Teitelbaum, MD (AAP)

At the September 2024 CPT Editorial Panel meeting, one new Category I code was created to report percutaneous electrical nerve field stimulation of cranial nerves and the existing Category III code, 0720T, was deleted. This procedure provides patients with a non-opioid therapy for the treatment and management of abdominal pain. This treatment typically lasts four weeks where patients return to the office for device placement each week. The new code was surveyed for the January 2025 RUC meeting.

64567 ***Percutaneous electrical nerve field stimulation, cranial nerves, without implantation***
The RUC reviewed the survey results from 51 pediatric gastroenterologists and recommends a work RVU of 1.50 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 11 minutes of pre-service time, 20 minutes intra-service time, 8 minutes immediate post-service time, and 39 minutes total time. The specialties and RUC agreed to recommend the pre- and post- time from the targeted industry sample which received 39 responses. It is not typical to report an E/M in conjunction with the surveyed code.

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For this procedure, The physician examines the skin behind the ear. Transillumination of the ventral and dorsal aspects of the external ear is performed to visualize the cranial and occipital neurovascular bundles. The area is then cleaned with alcohol wipes and marked with a surgical pen. The needle arrays are placed on the ventral/dorsal side of the ear lobe. The electrical nerve field stimulator is positioned behind the patient's ear, activated, re-positioned as needed, and secured in final placement with adhesives.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.92, 47 minutes total time) and second key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30, 30 minutes total time). The key reference services appropriately bracket the surveyed code work RVU. Further, when compared to the two key reference services and other codes with a similar work RVU, intra-service time, and total time, the surveyed code falls appropriately in the middle of those services supporting the relativity of the recommendation.

For additional support, the RUC referenced MPC codes 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20, 20 minutes intra-service time, 50 minutes total time) and 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.75, 20 minutes intra-service time, 40 minutes total time). The surveyed code is appropriately bracketed by the MPC reference codes and supports the relativity of the recommended work RVU. **The RUC recommends a work RVU of 1.50 for CPT code 64567.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. The PE Subcommittee acknowledged the new high-cost supply input, *IB-Stim Device Kit,* as recommended for CPT code 64567. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology/New Services
CPT code 64567 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years.

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Percutaneous Decompression of Median Nerve (Tab 14)
Michael Booker, MD (ACR), Carlo Milani, MD (AAPM&R), Anne Miller, MD (ASSH), Noah Raizman, MD (ASSH)

At the September 2024 CPT Editorial Panel meeting, one new Category I code was created to report percutaneous decompression of the median nerve at the carpal tunnel using ultrasound guidance and a balloon dilation device while transecting the transcarpal ligament. This new technology procedure was previously reported with unlisted code 64999. The new code was surveyed for the January 2025 RUC meeting as a 000-day global service given that postoperative care is not required for a majority of patients. For example, sutures are not used, so suture removal is not necessary; the patient is instructed to remove the bandage and steri-strips within two days, and physical therapy is not needed.

64728 ***Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance***
The RUC reviewed the survey results from 60 physicians from multiple specialties, including surgeons (hand, orthopaedic, plastic, neurosurgery), sports medicine, physical medicine and rehabilitation, and radiology. The RUC determined that the survey respondents may have overestimated work relative to the key reference services and recommends a work RVU of 2.70 based on a direct crosswalk to MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70, 20 minutes intra-service, 60 minutes total time), to maintain relativity within the payment schedule for this code. The RUC recommends 18 minutes of pre-service evaluation time, 3 minutes positioning time, 6 minutes scrub/dress/wait time, 20 minutes intra-service time, 10 minutes immediate post-service time, and 57 minutes total time.

For this procedure, a 0.5 cm incision is made through the skin and distal forearm fascia in the proximal wrist crease. This service is performed under continuous ultrasound guidance to monitor balloon inflation which pushes the soft tissue and surrounding vital anatomy (eg, median nerve and ulnar artery) to create space for the anticipated transection pathway. The complexity of this service involves ensuring that the nerve and nerve branches are kept intact while the surgeon is going from the longitudinal plane to the transverse plane back and at multiple levels to transect the transverse carpal ligament (TCL) and any remaining fibers.

To support the RUC recommended work RVU, the RUC referenced other codes with a 000-day global period, a similar work RVU, and similar intra-service and total time. CPT codes 43249 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)* (work RVU = 2.67, 20 minutes intra-service time, 57 minutes total time) and 31295 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa* (work RVU = 2.70, 20 minutes intra-service time, 56 minutes total time) appropriately bracket the surveyed code and support the relativity of the recommended work RVU. **The RUC recommends a work RVU of 2.70 for CPT code 64728.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made minor modifications to the pre-service clinical staff time for the non-facility inputs. The PE Subcommittee acknowledged that the pre-service clinical staff time for 000- and 010-day global codes is presumed to be zero and determined that the standard pre-service time of zero minutes is appropriate for this code for the non-facility setting. Therefore, the recommended time was revised to zero minutes for CA001 *Complete pre-service diagnostic and referral forms* and CA005 *Complete pre-procedure phone calls and prescription*. The PE Subcommittee agreed with the specialties' use of the pre-service time package for "Minimal Use of Clinical Staff" in the facility only.

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The PE Subcommittee acknowledged the new high-cost supply input, *Kit, UltraguideCTR,* as recommended for CPT code 64728. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

New Technology
CPT code 64728 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years.

Coronary Atherosclerotic Plaque Assessment (Tab 15)
Michael Booker, MD (ACR), Kanae Mukai, MD (SCCT), Richard Wright, MD (ACC), Cindy Yuan, MD (ACR)

In September 2024, the CPT Editorial Panel approved the addition of a new Category I code to report automated quantification and characterization of coronary atherosclerotic plaque to assess the severity of coronary disease derived from augmentative software analysis with interpretation and report by a physician or qualified health care professional, and the deletion of the four existing Category III codes.

75574 ***Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)***
CPT code 75574 was identified as part of the code family and there was an expectation for this code to be surveyed. The specialty societies declined to survey CPT code 75574 because they do not believe it is part of this family of services. The specialty societies indicated that CPT code 75577 is a distinct and non-overlapping service compared to CPT code 75574 and AI-driven analysis of 75577 is not a reason to survey code 75574. **The RUC submits no recommendation for CPT code 75574**.

75577 ***Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional***
The RUC reviewed the survey results from 129 cardiologists and radiologists and determined that the survey 25th percentile work RVU of 0.85 appropriately accounts for the physician work typically involved in this service. The RUC recommends 5 minutes pre-service time, 15 minutes intra-service time, and 7 minutes post-service time for 27 minutes total time as supported by the survey.

CPT code 75577 describes the quantification and characterization of coronary atherosclerotic plaque to assess the severity of coronary disease which must be derived from augmentative software analysis using data from coronary computed tomographic angiography (CCTA) and then separately interpreted by a physician or other qualified health care professional with a unique report. The additional data from 75577 is used to enhance physician decision-making for treatment planning and it is only ordered if indicated by the CCTA. This service occurs after the original CCTA is interpreted and is typically performed on a different day, frequently by a different physician, due to the delay from software analysis processing time, which can take 3-4 hours.

To justify a work RVU of 0.85, the RUC compared CPT code 75577 to the top key reference service code 75580 *Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional* (work RVU

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= 0.75, 11 minutes intra-service time and 22 minutes total time) and noted that both codes are cardiac augmentative software analysis codes derived from coronary CT angiography in similar patient populations. The surveyed code has more intra-service and total time and is therefore appropriately valued higher than the reference service. The RUC also compared CPT code 75577 to the second key reference service code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.75, 20 minutes intra-service time and 40 minutes total time) and noted that the reference service is an imaging study with more intra-service and total time and is therefore appropriately valued higher than 75577. The RUC noted that the survey 25th percentile value is appropriately bracketed by the two key reference service codes.

For additional support, the RUC compared CPT code 75577 to MPC code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time) and noted that the surveyed code has more intra-service and total time, while the comparator code is a nuclear bone scan that involves assessment of a lower complexity imaging and results in a similar amount of physician work due to the lower intra-service time and overall higher intensity. The RUC concluded that CPT code 75577 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.85 for CPT code 75577.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made one modification to remove the minutes from CA031 *Review examination with interpreting MD/DO*. The Subcommittee agreed with the standard times of 2 minutes for CA030 *Technologist QC's images in PACS, checking for all images, reformats, and dose page* and 1 minute for CA032 *Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.* The PE Subcommittee acknowledged the new high-cost supply input, *Plaque Characterization Analysis Software*, and did not deem this an indirect expense as it is utilized for the individual patient. **The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT code 75577 will be placed on the New Technology list and will be re-reviewed by the RUC in three years.

Radiation Oncology Treatment Delivery (Tab 16)
Alexander Harris, MD (ACRO), Christopher Jahraus, MD (ACRO), Michael Kuettel, MD (ASTRO), Amar Rewari, MD (ASTRO), Gerald White, MS (ASTRO), Catherine Yashsar, MD (ASTRO)

In October 2020, the RUC Relativity Assessment Workgroup (RAW) identified CPT codes G6012-G6015 as CMS/Other source with 2019 estimated Medicare utilization over 20,000. In January 2021, the RUC recommended the RAW review these services in two years (September 2023) after the CMS-issued *Radiation Oncology Advance Payment Model (RO Model)* is initiated (which includes these codes). The specialty society continued to advocate for the RUC recommended values and direct PE inputs for the existing CPT codes. In September 2023, the RAW reviewed the action plan for CPT codes G6012-G6015 and noted that in 2022 the CMS Innovation Center delayed the RO Model. The American Society for Radiation Oncology (ASTRO) began developing an episode-based alternative payment approach for radiation therapy services called Radiation Oncology Case Rate

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(ROCR). Thus, the specialty societies initially requested maintaining the inputs for all the codes in the radiation treatment delivery family and removing them from this CMS/Other screen. The RAW disagreed and noted that the inputs for these services were last reviewed in 2014, CMS did not accept the RUC recommendations, and the inputs may not represent the services as they are currently performed. The RAW discussed reviewing these services for practice expense at the next meeting. The specialty societies indicated that they would bring the code set back to CPT to correctly define the services and attempt to address CMS' concerns. The RAW referred radiation treatment delivery services G6001-G6017, 77402, 77407, 77412, 77385, 77386, 77387 and 77014 to the CPT Editorial Panel for revision.

In September 2024, the CPT Editorial Panel reviewed the radiation oncology code change application (CCA) which proposed to establish a technique agnostic family of codes and bundle imaging into all three services. The Panel approved the revision of 77402, 77407 and 77412 and the deletion of existing codes 77385, 77386 and 77014. The related guidelines and tables were updated to reflect the consolidated services for radiation treatment delivery. The specialty societies also requested that CMS delete the related G-codes G6001-G6017. The five-code family was surveyed for the January 2025 RUC meeting. Only CPT code 77387 was surveyed for physician work.

77387 ***Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed***
The RUC reviewed the survey results from 102 radiation oncologists and determined that the survey 25th percentile work RVU of 0.70 appropriately accounts for the physician work typically required to perform this service. The work of CPT code 77387 involves clinical interpretation of the positional relationship of the planned isodose versus what would be the actual isodose distribution. This is accomplished by examining the images acquired immediately prior to treatment delivery and their relationship to the images acquired at simulation, and if any over or underdosing at the targeted isocenter and adjacent organs at risk is likely, similar to diagnostic radiology. The RUC recommends 3 minutes pre-service time, 10 minutes intra-service time, and 3 minutes immediate post-service time for 16 minutes total time as supported by the survey.

To justify a work RVU of 0.70, the RUC compared CPT code 77387 to the top key reference service code 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation* (work RVU = 0.79, 15 minutes intra-service time and 25 minutes total time) and noted that the reference service has more intra-service time and total time and is appropriately valued higher than the surveyed code. Nonetheless, the RUC noted that 92% of the survey respondents that selected the first key reference service rated 77387 as identical or more intense and complex overall relative to the reference code. The RUC also compared CPT code 77387 to the second key reference service code 72192 *Computed tomography, pelvis; without contrast material* (work RVU = 1.09, 10 minutes intra-service time and 18 minutes total time) and noted the identical intra-service time and similar total time, yet the reference code is more intense, justifying a higher work value than 77387.

For additional support, the RUC compared CPT code 77387 to MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) noting the strong comparison in the amount of physician work, similar intra-service time and identical total time. The RUC also compared 77387 to MPC code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 10 minutes intra-service time and 20 minutes total time) and noted that the intra-service

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time is identical, yet the reference code has greater intensity and total time and is therefore appropriately valued higher than the surveyed code. The RUC offered another diagnostic radiology code 77076 *Radiologic examination, osseous survey, infant* (work RVU = 0.70, 10 minutes intra-service time and 18 minutes total time) for additional support, noting the services require the same amount of physician work and intra-service time.

The RUC noted that within radiation oncology services, the intensity of 77387 is most like the intensity for the planning code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU = 7.99, 130 minutes intra-service time and 195 minutes total time). The specialties explained that this makes sense as the intensity for work of 77387, analyzing how images acquired immediately prior to treatment delivery would affect the fraction specific dose delivered to targets and organs at risk, should be the same as the intensity for work of analyzing the total dose delivered to targets and organs at risk during the creation of the initial plan in 77301.

The RUC concluded that CPT code 77387 should be valued at the 25th percentile work RVU as supported by the survey and to maintain relativity within the services with similar XXX surveyed codes with 10 minutes of intra-service time. **The RUC recommends a work RVU of 0.70 for CPT code 77387.**

Practice Expense
A custom Practice Expense (PE) survey was created for CPT codes 77402, 77407, 77412. The specialties conducted a practice expense survey, with a Research Subcommittee approved tool, for CPT codes 77402, 77407 and 77412. The specialties also convened a consensus panel that included physicians and clinical staff who perform radiation oncology procedures in both the non-facility and facility settings. The consensus panel developed the direct practice expense recommendations for CPT codes 77402, 77407 and 77412 based on the survey data, best practices and current AMA RUC/PE guidelines. CPT code 77417 is a radiation oncology service with stand-alone procedure time, however, the equipment used is not over $1M. As such, the specialties used the consensus panel to develop direct practice expense recommendations for 77417 based on best practices and current AMA RUC/PE guidelines. CPT code 77387 is a PC/TC code. As such, the specialties used the consensus panel to develop direct practice expense recommendations for 77387 based on best practices and current AMA RUC/PE guidelines.

For CPT codes 77402, 77407 and 77412, the RUC reviewed the survey results from over 75 radiation oncologists and noted that the descriptions of work in the PE SOR clearly outline the duties of the two L050C *Radiation Therapists* in CA021 *Perform procedure/service---NOT directly related to physician work time.* The Subcommittee agrees that radiation therapists are doing concurrent, but distinct clinical activities critical in performing the service, and the PE SOR states that the current CMS policy is two radiation therapists for treatment delivery.

The PE Subcommittee reviewed the practice expense recommendations for the code family and approved the inputs with no modifications. The PE Subcommittee acknowledged the updated pricing information submitted for the following three existing equipment inputs: ER056 *Radiation Treatment Vault*, ER065 *Water Chiller (radiation treatment)* and ER089 *IMRT Accelerator* as well as the specialties' request to rename ER089 to "Radiation Treatment Delivery Linear Accelerator." **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

G-Codes
The RUC requests that CMS delete G6001-G6017 since CPT codes 77402, 77407, 77412 and 77417 have been revised and may be used to report these services instead.

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Superficial Radiation Therapy (Tab 17)
Brad Glick, DO (AADA), Ryan Hick, MD (AADA), Christopher Jahraus, MD (ACRO), Brent Moody, MD (AADA), William Posten, MD (AADA), Amar Rewari, MD (ASTRO)

In October 2019, code 0394T was identified via the Relativity Assessment Workgroup's (RAW's) high-volume category III codes screen based on 2018 Medicare utilization data over 1,000. In January 2020, the RUC recommended maintaining this service and review in 3 years (Sept 2023). In September 2023, the RUC recommended that this service be referred to CPT May 2024 to create a Category I code.

Additionally, in October 2020, code G6001 was identified by the RAW via the CMS/Other Medicare utilization over 20,000 screen. In January 2021, the RUC recommended referring G6001 to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology). Over a year later, a Category I code had not been created, therefore this issue was placed back on the RAW for review at the April 2022 Workgroup meeting. In April 2022, the Workgroup agreed with the specialty society that the specialties work with CMS to develop a MLN Matters article to clarify correct coding and that the Workgroup re-review in two years (April 2024). In September 2023, the Workgroup reviewed an action plan related to other radiation treatment delivery codes G6012-G6015, the specialty societies initially requested maintaining the inputs for all the codes in the radiation treatment delivery family and removing them from this CMS/Other screen. The Workgroup disagreed and noted that the inputs for these services were last reviewed in 2014, CMS did not accept the RUC recommendations and the inputs may not represent the services as they are currently performed. The Workgroup discussed reviewing these services for practice expense at the next meeting. The specialty societies indicated that they would bring the code set back to CPT to correctly define and attempt to address CMS' concerns.

In September 2024, the CPT Editorial Panel created four codes and a new subsection to report surface radiation therapy. The existing Category III code, 0394T, and one Category I code, 77401, were deleted. The code family was surveyed for the January 2024 RUC meeting.

Superficial and orthovoltage radiotherapy utilize low energy ionizing radiation to treat cancer and other conditions that occur either on or close to the skin surface. Simulation-aided field setting for superficial radiation therapy (SRT) is currently reported using CPT code 77280 *Therapeutic radiology simulation-aided field setting; simple*. The new code family provides a series of CPT codes—covering planning, simulation, and treatment delivery—that describe SRT, performed typically by dermatology, and includes a combination of professional/technical services to allow for the reporting of services performed. As a result, SRT treatment planning and simulation-aided field setting will be reported with the new CPT code 77436. The reporting of 77280 for SRT will be prohibited under new CPT guidelines.

Compelling Evidence
The RUC agreed with the specialty societies that there is compelling evidence to support a change in physician work for the code family based on a change in dominant specialty as Dermatology did not participate in the prior RUC survey. At the January 2013 meeting, the RUC recommended a work RVU of 0.70 for 77280, based on a survey that consisted only of Radiation Oncology. The typical current predominant diagnosis for 77280 is skin cancer and the dominant specialty is Dermatology, which was not the case in 2013.

In addition, the vignette for the 2013 valuation of 77280 is substantially different than the vignette for the new code 77436. The vignette for 77280 described therapeutic radiation field setting to the lumbar spine in a patient with metastatic prostate cancer, while the vignette for 77436 describes the typical

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patient undergoing treatment planning for surface radiation therapy to treat a localized squamous cell carcinoma on the shin.

The RUC concurred that there is compelling evidence that the physician work for these services has changed due to a previous valuation excluded a specialty that currently provides a plurality of the service and a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation.

77436 ***Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting***
The RUC reviewed the survey results from 64 dermatologists and radiation oncologists and concluded that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU = 0.77, 20 minutes intra-service time and 37 minutes total time), which falls below the survey 25th percentile and has nearly identical intra-service time, appropriately accounts for the physician work involved in this service. The RUC noted that the value is similar to the current code being reported 77280 which has a work RVU of 0.70 and is also similar to the survey responses by dermatologists with the survey 25th percentile work RVU of 0.80. The RUC recommends 7 minutes pre-service time, 19 minutes intra-service time, 10 minutes post-service time for 36 minutes total time as supported by the survey. The typical course of superficial radiation therapy for the treatment of skin cancer consists of approximately fifteen treatments, with the appropriate treatment delivery code (e.g., 77437) reported for each session. Based on the current usage of CPT code 77280, the RUC clarified that the new planning code, 77436, will be used multiple times throughout the treatment course."

To justify a work RVU of 0.77, the RUC compared CPT code 77436 to both the key reference service codes 77262 *Therapeutic radiology treatment planning; intermediate* (work RVU = 2.00, 45 minutes intra-service time, and 54 minutes total time) and 77261 *Therapeutic radiology treatment planning; simple* (work RVU = 1.30, 30 minutes intra-service time, and 36 minutes total time) and noted that the key reference services have much more intra-service and total time and are more intense than 77436, therefore the reference codes are appropriately valued higher than the surveyed code. The RUC also compared CPT code 77436 to MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30, 20 minutes intra-service time and 30 minutes total time) noting that the comparator code has slightly more intra-service time and is much more intense than the surveyed code and is therefore appropriately valued higher.

For additional support, the RUC noted a strong comparison between CPT code 77436 and CPT code 93280 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system* (work RVU = 0.77, 15 minutes intra-service time and 32 minutes total time) which has the same amount and intensity of physician work, yet less intra-service and total time. The RUC also referenced CPT codes 62370 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)* (work RVU = 0.90, 20 minutes intra-service time and 37 minutes total time) and 38226

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Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage) (work RVU = 0.79, 18 minutes intra-service time and 28 minutes total time) for additional justification.

The RUC concluded that CPT code 77436 should be valued based on a direct work RVU crosswalk to CPT code 95991, noting that both services involve nearly identical intra-service and total time, and agreed the crosswalk value below the survey 25th percentile was appropriate. **The RUC recommends a work RVU of 0.77 for CPT code 77436.**

77439 ***Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (List separately in addition to the code for primary procedure)***
The RUC reviewed the survey results from 51 dermatologists and radiation oncologists and determined that the survey 25th percentile work RVU of 0.30 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 10 minutes intra-service and total time as supported by the survey. Reporting of the new add-on code is limited to once per course of treatment.

Ultrasound guidance for the placement of radiation therapy fields for SRT is currently reported using HCPCs code *G6001 Ultrasonic guidance for placement of radiation therapy fields*. The new code family provides a series of CPT codes—covering planning, simulation, and treatment delivery—that describe SRT, performed typically by dermatology, and includes a combination of professional / technical services to allow for the reporting of services performed. As a result, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors for SRT will be reported with new CPT code 77439. **The RUC recommends deletion of HCPCS code G6001**.

To justify a work RVU of 0.30, the RUC compared CPT code 77439 to the top key reference service code 76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)* (work RVU = 0.30, 10 minutes intra-service and total time) and noted the strong comparison between the services which involve identical intra-service and total time and the same amount and intensity of physician work. The RUC also compared CPT code 77439 to the second key reference service code 77293 *Respiratory motion management simulation (List separately in addition to code for primary procedure)* (work RVU = 2.00, 45 minutes intra-service and total time) and noted that the reference service has much more intra-service and total time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC noted that recommended value for CPT code 77439 is appropriately bracketed between MPC codes 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20, 4 minutes intra-service time and 7 minutes total time) and 95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)* (work RVU = 0.35, 15 minutes intra-service and total time). The RUC concluded that CPT code 77439 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.30 for CPT code 77439.**

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Practice Expense
The Practice Expense (PE) Subcommittee considered the entire code family, CPT codes 77436 and 77439 alongside PE-only codes 77437 and 77438. Compelling evidence was not needed for the family but was provided for new code 77437 as the practice expense inputs are greater than the code it is replacing, CPT code 77401. The PE Subcommittee concurred that there is compelling evidence to support an increase over the aggregate current cost for clinical staff time, supplies and equipment based on changes in technology/updated equipment because the cost of the radiation delivery device typically used has increased. Compelling evidence was accepted under the recognized category of: Evidence that there has been a change in equipment or practice expense cost.

The PE Subcommittee reviewed the direct practice expense inputs and questioned discrepancies between the inputs for codes 77437 and 77438. The specialties explained that the codes are different procedures that utilize different pieces of equipment, involve different patient populations and different specialties. CPT code 77437 is for superficial delivery and will predominantly be reported by dermatology, while 77438 is for orthovoltage services and will be reported by radiation oncologists. For CPT code 77438, the PE Subcommittee acknowledged two new equipment items, *Orthovoltage Treatment Delivery System* and the *Orthovoltage Vault*. It was clarified that the equipment is typically purchased or leased.

The PE Subcommittee made one modification to CPT code 77436 to remove minutes from CA009 *Greet patient, provide gowning, ensure appropriate medical records* to eliminate potential overlap with 77437. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

G-Codes
The RUC requests that CMS delete G6001 since CPT codes 77436-77439 have been created and may be used to report superficial radiation therapy.

New Technology
The code family, CPT codes 77436, 77437, 77438 and 77439, will be placed on the New Technology list and will be re-reviewed by the RUC in three years.

Combination COVID-19 Vaccine Administration (Tab 18)
Suzanne Berman, MD (AAP), Brad Fox, MD (AAFP), Charles Hamori, MD (ACP), Korinne Van Keuren, DNP (ANA)

In September 2024, the CPT Editorial Panel created a new add-on code, 90481, to report when each additional non-COVID vaccine component is administered with the COVID-19 vaccine. CPT code 90480 was revised as part of this family of services.

90480 ***Immunization administration by intramuscular injection, ~~of~~ severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; first or only component of each vaccine administered***
In September 2023, the RUC reviewed CPT code 90480 and recommended the survey median work RVU of 0.25. The RUC recommended 7 minutes of intra-service/total time. The RUC noted that this service is typically performed on the same day as an Evaluation and Management (E/M) office visit and the recommended work and time is not duplicative from that which is included in the E/M visit. The specialty societies requested that the RUC affirm the work RVU for 90480 as it was recently surveyed. **The RUC recommends affirming a work RVU of 0.25 for CPT code 90480.**

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90481 ***Immunization administration by intramuscular injection, ~~of~~ severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; each additional component administered (List separately in addition to code for primary procedure)***
The specialty societies noted that 90481 does not have additional physician work or direct practice expenses associated with it. All work and direct practice expense is included in the administration of the base code 90480. The CDC requested this code for tracking multi-antigen vaccines outside the pediatric population. This add-on code is intended for use in the identification of a second component of the COVID combination vaccine. CPT code 90481 simply represents the second component of the product composition that was administered and provides a means to track the administration of the second vaccine. **The RUC recommends a work RVU of 0.00 for CPT code 90481.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. For CPT code 90480, the RUC affirmed the September 2023 inputs. No direct practice expense inputs were recommended for CPT code 90481 as it was developed for product tracking purposes only. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

Scalp Cooling Services (Tab 19)
Elizabeth Blanchard, MD (ASCO), Arturo Loaiza-Bonilla, MD (ASCO)

At the September 2024 CPT Editorial Panel meeting three new Category I codes were created to report medical scalp cooling services to address chemotherapy induced alopecia. Two existing Category III codes, 0662T and 0663T, were deleted. The new codes were surveyed for the January 2025 RUC meeting, however, the RUC determined that the code family requires no physician work and are practice expense (PE) only services.

97007 ***Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education***
The RUC reviewed the survey results from 35 oncologists and determined that this code requires no physician work and is a PE only service that requires an L056A *RN/OCN* to perform the clinical tasks. This service requires 2 minutes of CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* rather than the 3-minute standard because the patient is not wearing a gown. Five minutes of CA011 *Patient education/obtain consent* comprises education on how to affix the cap, hair and scalp care, maintenance of supply items, cleaning instructions, and storage instructions. Further, during the intra-service portion of the service period, 5 minutes for CA021 *Perform procedure/service—not directly related to physician work time* is required to examine the scalp and select a cap for the patient with accompanying instructions on the scalp cooling process, how it works with the infusion session, time expectations, and potential adverse events. Two minutes are required for CA024 *Clean room/equipment by clinical staff* which is below the 3-minute standard.

The PE Subcommittee acknowledged the new high-cost supply input, *Scalp Cooling Cap/Kit,* as recommended for CPT code 97007. The specialty societies clarified that the patient uses one cap for their chemotherapy treatment plan, so it is reusable for the one patient, after which it is considered medical waste due to the close skin contact and extended period of exposure to the chemotherapy during the time the cap is worn. **The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. Further, the RUC was not certain if the item is provided directly to the patient (rather than the practice) and if this might impact whether the cap would be considered Durable Medical Equipment by CMS. The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

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97008 ***Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and pre-cooling period***
The RUC reviewed the survey results from 32 oncologists and determined that this code requires no physician work and is a PE only service. CPT code 97008 is typically reported with 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug,* 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure),* and family code 97009.

This service requires 9 minutes total clinical staff time, 2 minutes of CA013 *Prepare room, equipment and supplies* and 7 minutes of CA021 *Perform procedure/service—not directly related to physician work time*. For CA021, activities include the preparation of hair for scalp cooling, fitting the individual cooling cap, thermal cover, and protective headband to the patient's head, and attaching the cap to the continuously monitored cooling system.

The RUC and PE Subcommittee determined that the recommended new equipment item, *Scalp Cooling System*, is leased equipment that may be used by more than one patient simultaneously. Therefore, the RUC does not have a mechanism to apply a cost-per-minute formula. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

97009 ***Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 31 oncologists and determined that this code requires no physician work and is a PE only service. CPT code 97009 is typically reported with 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug,* 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure),* and family code 97008. Typically, three units of 97009 are reported per chemotherapy session.

The Practice Expense Subcommittee reviewed the direct practice expense inputs and reduced the 7 minutes of CA021 *Perform procedure/service—not directly related to physician work time* to 5 minutes because typical post-chemotherapy scalp cooling lasts 90 minutes for which 3 units of this add-on code would expect to be reported. The patient remains in the chemotherapy infusion chair post-infusion and is monitored throughout the remainder of scalp cooling. The post-service portion of the service period requires 1 minute of CA024 *Clean room/equipment by clinical staff* rather than the full 3 minute standard as the specialty divided the standard by three to account for the typical 3 episodes.

Similar to 97008, the recommended new equipment item, *Scalp Cooling System,* is a leased equipment that may be used by more than one patient simultaneously. Therefore, the RUC does not have a mechanism to apply a cost-per-minute formula. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 97007, 97008, and 97009 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years.

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Remote Monitoring (Tab 20)
Brad Fox, MD (AAFP), Charles Hamori, MD (ACP), Carlo Milani, MD (AAPM&R), Angela Pennisi, DPT (APTA), Korinne Van Keuren, DNP, (ANA), Richard Wright, MD (ACC)

In April 2022, the RUC identified code 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* as part of a Relativity Assessment Workgroup (RAW) screen for services that were surveyed by one specialty but are now typically performed by a different specialty. In September 2022, the RAW reviewed an action plan on this service and recommended the service be reviewed in two years (2021-2022 data) after utilization stabilized following the pandemic. In April 2024, the RAW noted that 99457, along with the codes 99453, 99454 and 99458 were on the new technology/new services list for review. The specialty societies indicated that a CPT code change application (CCA) was submitted for May 2024 to review remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) codes (which may require surveying of these codes) and to refer this issue to CPT Assistant regarding correct coding of this family of services. The RAW recommended that this code family be reviewed at the next RAW meeting in September 2024, to summarize what has occurred at the CPT Editorial Panel. The RAW noted that if this family were not addressed via the upcoming CPT process, the RAW should discuss when it would be surveyed. In September 2024, the RAW noted that a CCA for remote monitoring was reviewed at the September 2024 CPT meeting, which included codes 99453-99458. The RUC noted that 99453-99458 needed to be surveyed because the utilization of 99457 significantly increased and the primary specialties who perform these services did not participate in the original survey.

In September 2024, the CPT Editorial Panel added one code and made code revisions to report RPM device supply for 2-15 days and 16-30 days within a 30-day period to report RPM parameters; created one new code and code revisions to report RPM treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; added three RTM device supply codes to report respiratory, musculoskeletal and cognitive behavioral therapy for 2-15 days and 16-30 days within a 30-day period; created one new code and made code revisions to report RTM treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; and revised the "Digitally Stored Data Services/Remote Physiologic Monitoring" guidelines, "Remote Physiologic Monitoring Treatment Management Services" guidelines, "Remote Therapeutic Monitoring Services" guidelines, and the "Remote Therapeutic Monitoring Treatment Management Services" guidelines.

Remote Physiologic Monitoring (RPM)

Remote physiologic monitoring (RPM) represents the remote monitoring of parameters such as weight, blood pressure and pulse oximetry for the purposes of monitoring a patient's condition to inform their management. CPT codes 99453, 99445 and 99454 are practice expense only codes that describe remote monitoring of physiologic parameters for the initial set up, daily recordings or programmed alerts transmissions for 2-15 days and 16-30 days. Additionally, CPT code 99473 is a practice expense only code for self-measured blood pressure using a validated device with patient education/training and device calibration.

CPT codes 99091, 99474, 99470, 99457 and 99458 are all services that require physician work. When these services were surveyed for the January 2025 RUC meeting, the survey response threshold was not met. CPT codes 99091 and 99474 are performed under 100,000 times in the Medicare population, therefore 30 responses are required and CPT codes 99470, 99457 and 99458 are performed over 1 million times in the Medicare population and at least 75 responses are required. The RUC's policy is

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that surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting. These minimum survey thresholds apply to both existing codes and any new codes with estimated Medicare claims of these amounts. However, the RUC discussed and agreed that conducting another survey immediately would most likely not produce a better result. Also, the dominant specialties continue to fluctuate. **The RUC recommends that CPT codes 99091, 99474, 99470, 99457 and 99458 be resurveyed after one year of utilization data is available for this CPT 2026 code structure. All RPM codes will be reviewed at the January 2028 RUC meeting.**

99091 ***Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days***
The RUC reviewed the survey results from 28 physicians and nurse practitioners and determined the survey 25th percentile work RVU of 0.70 appropriately accounts for the work typically required to perform this service. This code is a time-based code requiring a minimum of 30 minutes of physician or other qualified health care professional time over a 30-day period and may not be reported if 30 minutes is not met. The RUC agreed that the intra-service time for this code should be modified to be 30 minutes as the CPT descriptor clearly states that the physician must spend a minimum of 30 minutes to report this service. The RUC recommends 30 minutes of intra-service and total time.

The RUC compared the surveyed code to the top key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30, 20 minutes intra-service time and 30 minutes total time) and determined although these services require the same amount of total time, the surveyed code is much less intense and complex to perform, therefore appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) and determined these services require the same physician work to perform, thus are valued the same.

For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report (eg, Gibbons or double-J type)* (work RVU = 0.70, 15 minutes intra-service time and 20 minutes total time) and 93015 *ardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time and 26 minutes total time), both which require similar physician work and time to perform. The RUC determined that the survey 25th percentile work value of 0.70 appropriately places CPT code 99091 relative to other services in the Medicare Physician Payment Schedule (MFS) based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.70 for CPT code 99091.**

99474 ***Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient***

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The RUC reviewed the survey results from 28 physicians and nurse practitioners and determined the current value of 0.18 appropriately accounts for the work typically required to perform this service. The specialty societies indicated that the service has not changed and there was not compelling evidence that the physician work has increased. The RUC noted that the new survey times result in a negative IWPUT. Therefore, the RUC recommends the current time of 3 minutes pre-service evaluation time, 5 minutes intra-service time and 2 minutes immediate post-service time.

The RUC compared the surveyed code to MPC codes 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 3 minutes intra-service time and 6 minutes total time) and 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* (work RVU = 0.18, 5 minutes intra-service time and 7 minutes total time), which require similar physician work and time to perform. The RUC determined that the current work value of 0.18 appropriately places CPT code 99474 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.18 for CPT code 99474.**

99470 ***Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes***

The RUC reviewed the survey results from 17 physicians and determined the survey 25th percentile work RVU of 0.39 appropriately accounts for the work required typically to perform this service. The RUC recommends 10 minutes intra-service and total time. The RUC noted that this time-based code is reported when the clinical staff, physician and/or QHP have collectively spent 10-19 minutes performing RPM treatment management services for a patient in a calendar month. This code may not be reported if the service is performed for less than 10 minutes in a calendar month. RPM treatment management services have distinct reporting rules from RTM treatment management services. RTM treatment management services are also time-based codes, however, unlike RPM, their reporting is only based on physician or QHP time. A separate question was included in the survey asking, "*How much CLINICAL STAFF time (ie RN, LPN, MTA) is required per patient treated for each of the following steps in patient care related to this service?"* For CPT code 99470 the median clinical staff time was 9 minutes. The physician/QHP time of 10 minutes, plus the 9 minutes of clinical staff time, totals 19 minutes, which appropriately fits in the coding structure for this code requiring less than 20 minutes. Whereas CPT code 99457 would be reported for RPM requiring 20-39 minutes.

The RUC compared the surveyed code to the top key reference code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50, 15 minutes intra-service and total time) and determined that the surveyed code requires less physician time and therefore is appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.39, 8 minutes intra-service and 15 minutes total time) and determined these services require the same physician work to perform, with the surveyed code requiring less total time but being slightly more intense and complex.

For additional support the RUC referenced MPC codes 71111 *Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views* (work RVU = 0.32, 7 minutes intra-service time and 9 minutes total time) and 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes intra-service time and 12 minutes total time) both which bracket the surveyed code and is comparable for physician work and time. The RUC determined that the survey 25th percentile work

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RVU of 0.39 appropriately places CPT code 99470 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.39 for CPT code 99470.**

99457 ***Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 20 minutes***

The RUC reviewed the survey results from 22 physicians and determined the survey 25th percentile work RVU of 0.45 appropriately accounts for the work typically required to perform this service. The RUC recommends 14 minutes intra-service and total time. The RUC noted that this time-based code is reported when the clinical staff, physician and/or QHP have collectively spent 20-39 minutes performing RPM treatment management services for a patient in a calendar month. This code may not be reported if the service is performed for less than 20 minutes in a calendar month. RPM treatment management services have distinct reporting rules from RTM treatment management services. RTM treatment management services are also time-based codes, however, unlike RPM, their reporting is only based on physician or QHP time. A separate question was included in the survey asking, "*How much CLINICAL STAFF time (ie RN, LPN, MTA) is required per patient treated for each of the following steps in patient care related to this service?"* For CPT code 99457 the median clinical staff time was 20 minutes. The physician/QHP time of 14 minutes, plus the 20 minutes of clinical staff time, totals 34 minutes, which appropriately fits in the coding structure requiring 20-39 minutes to report.

The RUC compared the surveyed code to the top key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30, 20 minutes intra-service time and 30 minutes total time) and determined that the surveyed code requires less physician work and time and therefore is appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50, 15 minutes intra-service and total time) and determined that the surveyed code requires similar physician work and time, thus is appropriately valued similarly.

For additional support the RUC referenced MPC codes 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVU = 0.50, 7 minutes intra-service time and 17 minutes total time), and 92250 *Fundus photography with interpretation and report* (work RVU = 0.40, 10 minutes intra-service time and 12 minutes total time) both of which bracket the surveyed code and are comparable for physician work and time. The RUC determined that the survey 25th percentile work RVU of 0.45 appropriately places CPT code 99457 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.45 for CPT code 99457.**

99458 ***Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 18 physicians and determined the survey 25th percentile and current work RVU of 0.61 appropriately accounts for the work typically required to perform this service. The RUC recommends 16 minutes intra-service and total time. This code is a time-based code requiring a minimum of an additional 20 minutes and may not be reported if 20 minutes is not

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met. For example, the first unit of this add-on code cannot be reported until at least 40 minutes of RPM treatment management has been performed (99457 X 1 unit, 99458 X 1 unit). The RUC noted that this code includes the work of not only a physician and QHP but also clinical staff. A separate question was included in the survey asking, "*How much CLINICAL STAFF time (ie RN, LPN, MTA) is required per patient treated for each of the following steps in patient care related to this service?"* For CPT code 99458 the median clinical staff time was 19 minutes. The RUC also noted that the median reporting for this code is once per claim according to the 2023 Medicare claims data. The physician/QHP time of 16 minutes, plus the 19 minutes of clinical staff time, totals 35 minutes, which appropriately fits in the coding structure requiring an additional 20-39 minutes to report after the first 20 minutes (99457). The RUC agreed that this add-on code 99458 for each additional 20 minutes is slightly more intense and complex than the base code 99457 because these patients are more complex and have multiple co-morbidities requiring the physician/QHP typically to spend more time to manage.

The RUC compared the surveyed code to the top key reference code 99437 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 1.00, 30 minutes of intra-service and total time) and determined that the surveyed code requires less physician work and time and therefore appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 0.70, 20 minutes intra-service and total time) and determined that the surveyed code requires slightly less physician work to perform, thus appropriately valued lower.

For additional support the RUC referenced MPC codes 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)* (work RVU = 0.54, 15 minutes intra-service time and 17 minutes total time), and 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service time and total time) both of which bracket the surveyed code and are comparable for physician work. The RUC determined that the survey 25th percentile work RVU of 0.61 appropriately places CPT code 99458 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.61 for CPT code 99458.**

Practice Expense - RPM

The Practice Expense (PE) Subcommittee considered and approved compelling evidence for the existing RPM codes, such as CPT code 99454, based on changes in technology, given the proliferation of vendors, and change in specialty as internal medicine is now the primary provider.

The PE Subcommittee reviewed the direct practice expenses for the RPM services and made a single modification to CPT code 99445 to reduce the equipment minutes by half from 43,200 to 20,160, based on the number of days 99445 is performed (2 to 15 days, not a full 30 days as with code 99454). The PE Subcommittee agreed with renaming equipment package EQ392 ~~*heart failure*~~ *patient*

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physiologic monitoring equipment package. Additionally, for 99445 and 99454, a new supply item was added for *digital remote physiologic monitoring device app,* for which an invoice was submitted for $6.62 per patient. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Work Neutrality for RPM
The RUC's recommendation for the remote physiologic monitoring codes 99453, 99445, 99454, 99091, 99473, 99474, 99470, 99457 and 99458 will result in overall work savings that should be redistributed back to the Medicare conversion factor.

New Technology/New Services - RPM
The use of RPM services continue to fluctuate in terms of the specialties who report and the monitoring that occurs. All the codes in this family would be considered new technology. Since CPT has split out the services it is unclear which technologies are used for each code based on the specific durations. It is also unclear who is predominantly providing these services. The RPM family of services will be placed on the New Technology list and resurveyed and reviewed by the RUC at the January 2028 meeting.

RUC Flag
The RUC notes that it will flag remote physiologic monitoring codes 99453, 99445, 99454, 99091, 99473, 99474, 99470, 99457 and 99458 as do not use to validate physician work in the RUC database due to the low survey response. These services will be resurveyed for the January 2028 RUC meeting.

Remote Therapeutic Monitoring (RTM)

Remote therapeutic monitoring (RTM) represents the monitoring of adherence to at-home therapeutic interventions. RTM can be provided for a variety of conditions, and there are distinct device supply codes which are PE only that have been created for three types of therapeutic monitoring currently respiratory system, cognitive behavioral therapy and musculoskeletal system monitoring.

CPT codes 98975, 98984, 98976, 98985 and 98977 are practice expense only codes that describe remote therapeutic monitoring for the initial setup and device supply for data access or data transmissions for 2-15 days and 16-30 days for monitoring both the respiratory system (98984 & 98876) and musculoskeletal system (98985 and 98977). Additionally, CPT codes 98986 and 98978 are practice expense only codes for device
supply for data access or data transmissions for 2-15 days and 16-30 days for monitoring of cognitive behavioral therapy. Codes 98986 and 98978 are reported primarily by non-MD/DOs and, therefore, were reviewed separately by the Health Care Professionals Advisory Committee (HCPAC) Review Board.

CPT codes 98979, 98980 and 98981 are RTM treatment management services that describe physician or other qualified health care professional work for the first 10 minutes, first 20 minutes and each additional 20 minutes. These services were surveyed for January 2025, and each met the survey threshold of at least 30 responses. RTM treatment management services have distinct reporting rules from RPM treatment management services. RTM treatment management services are time-based codes, however, unlike RPM, their reporting is only based on physician or QHP time

RTM technology treatment data is collected and analyzed asynchronously by a physician or QHP and additional treatment decisions are provided through at least one real-time communication as an adjunct to in-person care. RTM is provided to patients who might need extra support and asynchronous oversight in between in-person physical therapy visits to progress their self-

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management program. The specialty societies noted that the application used for these services is not an exercise app, but a therapy delivery app providing data regarding how the therapy is progressing and the physician/QHP is making decisions about how to modify therapy based on that data**.**

Compelling Evidence
The specialty societies indicated compelling evidence that there has been a change in physician/QHP work due to a change in patient population resulting from a diffusion of technology of the procedure in physical therapy. It is supported by the change in the performance rate of the service between the 2021 survey and the 2024 survey, as well as the change in the vignette which is supported by the survey results.

Change in Population
When the RTM codes were originally surveyed in 2021, an asthmatic patient was described as the typical patient in the vignette, primarily connected to the codes for respiratory therapy monitoring. However, these vignettes were found to be typical by less than 50% of survey respondents in 2021. The vignettes for 98980 and 98981 were updated for the 2024 survey to reflect the typical patient being a musculoskeletal/osteoarthritis patient. 100% of survey respondents found these vignettes to be typical. The specialty societies noted that the low support for the vignettes in 2021 suggests an additional compelling argument that incorrect assumptions were made in the previous valuation of the service. The RUC noted that these services continue to change and fluctuate on the dominant providers shifting between physical therapy and family medicine/internal medicine. Additionally, the top diagnoses have changed and reflect musculoskeletal issues.

Diffusion of Technology
Since 2021, there has been a diffusion of RTM technology, primarily in physical therapy practice. In 2021, these codes were added to the new technology list, and since that time the service has been embraced by physical therapy as a result of the increased availability of the technology and a positive response by patients to incorporate this procedure into the rehabilitative process. Rates of experience for these services were very low in the 2021 survey, with the median performance rate of 1 for 98980 and the median rate of 0 for 98981. In the new survey, these performance rates increased to a median experience rate of 10 for 98980 and 4 for 98981. This suggests the services have been more widely adopted, primarily by physical therapy.

The RUC agreed with the specialty societies that there is compelling evidence that the patient population has changed and there has been a diffusion of technology for the RTM services.

98979 ***Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes***
The RUC reviewed the survey results from 32 physical medicine and rehabilitation physicians and physical therapists and determined the survey 25th percentile work RVU of 0.66 appropriately accounts for the work required to perform this service. The RUC recommends 16 minutes intra-service and total time. The RUC noted that this time-based code is reported when the physician or QHP has spent 10-19 minutes performing RTM treatment management services for a patient in a calendar month. This code may not be reported if the service is performed for less than 10 minutes in a calendar month.

The RUC compared the surveyed code to the top key reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.* (work RVU =

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0.70, 11 minutes intra-service time and 16 minutes total time) and determined that the surveyed code requires slightly less physician work and thus is appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 99451 *Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time* (work RVU = 0.70, 15 minutes intra-service and 23 minutes total time) and determined that the surveyed code requires slightly less physician work and time to perform, thus is appropriately valued lower.

For additional support the RUC referenced MPC codes 85060 *Blood smear, peripheral, interpretation by physician with written report* (work RVU = 0.45, 12 minutes intra-service time and total time) and 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report (eg, Gibbons or double-J type)* (work RVU = 0.70, 15 minutes intra-service time and 20 minutes total time), both which bracket the surveyed code and is comparable for physician work and time. The RUC determined that the survey 25th percentile work RVU of 0.66 appropriately places CPT code 98979 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.66 for CPT code 98979.**

98980 ***Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 20 minutes***
The RUC reviewed the survey results from 32 physical medicine and rehabilitation physicians and physical therapists and determined that survey 25th percentile work RVU of 0.78 appropriately accounts for the work required to perform this service. The RUC recommends 24 minutes intra-service and total time. The RUC noted that this time-based code is reported when the physician or QHP has spent 20-39 minutes performing RTM treatment management services for a patient in a calendar month.

The RUC compared the surveyed code to the top key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* (work RVU = 1.30, 20 minutes intra-service time and 30 minutes total time) and determined that the surveyed code requires less physician work and time and therefore appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 99451 *Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time* (work RVU = 0.70, 15 minutes intra-service and 23 minutes total time) and determined that the surveyed code requires slightly more physician work and time to perform, thus is appropriately valued higher.

For additional support the RUC referenced MPC codes 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50, 10 minutes intra-service time and 13 minutes total time), and 95972 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet*

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mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional (work RVU = 0.80, 23 minutes intra-service time and 36 minutes total time) both which bracket the surveyed code and is comparable for physician work and time. The RUC determined that the survey 25th percentile work RVU of 0.78 appropriately places CPT code 98980 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.78 for CPT code 98980.**

98981 ***Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 32 physical medicine and rehabilitation physicians and physical therapists and determined the survey 25th percentile work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes intra-service and total time for this add-on code.

The specialty societies noted and the RUC agreed that the physician work for 98981 requires more work and is slightly more intense than the base code 98980, because the typical patient who needs this service is a more complicated patient or a patient who is not coming into the office as frequently for in-person care, therefore needs to have more remote communication with the provider to manage their conditions.

The RUC compared the surveyed code to the top key reference service 99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 0.70, 20 minutes intra-service and total time) and determined that these services require the same physician work and time to perform, thus are valued the same. Patients receiving 98981 have chronic conditions and comorbidities, management of providing 98981 includes consideration of those chronic conditions and comorbidities. The RUC compared the surveyed code to the second top key reference code 99437 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 1.00, 30 minutes of intra-service and total time) and determined that the surveyed code requires less physician work and time and therefore appropriately valued lower.

For additional support the RUC referenced MPC codes 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)* (work RVU = 0.54, 15 minutes intra-service time and 17 minutes total time), and 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service time and total time) both which bracket the surveyed code and is comparable for physician work. The RUC

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determined that the survey 25th percentile work RVU of 0.70 appropriately places CPT code 99458 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.70 for CPT code 98981.**

Practice Expense - RTM
The Practice Expense (PE) Subcommittee considered and approved compelling evidence for the existing RTM codes based on change in technology (diffusion of knowledge) and change in patient population as evidenced by the updated vignette.

The PE Subcommittee reviewed the practice expense for the RTM codes and made several modifications. For CPT code 98975, the Subcommittee eliminated post-service clinical staff time CA037 *Conduct patient communications*. Additionally, CA037 was reduced by half to 10 minutes for 98979, 15 minutes for 98980 and 5 minutes for 98981. The patient communication inputs were reduced on the basis of the physical therapy sessions overlap with performing the RTM services. Supply item SJ056 *Thera-bands (6-in width)* was removed from CPT code 98975 because it is duplicative of the thera-bands available for the physical therapy sessions. Additionally, for CPT code 98975, based on the invoice provided, the specialty societies recommend a new supply item, *remote musculoskeletal therapy monitoring program enrollment fee*. This fee is a unique one-time fee per patient regardless of the duration on the RTM program. The fee is invoiced at $10 per patient. For 98985 and 98977, based on the invoice provided, the specialty societies recommend a new remote musculoskeletal therapy monitoring monthly supply fee of $45. This fee covers the use of the RTM technology per patient for 30 days. Finally, the PE Subcommittee recommends that 98984 and 98976 be contractor-priced as requested by the specialties. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Services - RTM
The RTM services continue to fluctuate. All the codes in this family would be considered new technology (98975, 98984, 98976, 98985, 98977, 98979, 98979, 98980 and 98981). Since CPT has split out the services, it is unclear which technologies are used for each code based on the specific durations. It is also unclear who is predominantly providing these services. The RTM family of services will be placed on the New Technology list to be reviewed after three years of data are available (April 2030).

RUC Flag - RTM
The RUC indicated that it would flag the remote therapeutic monitoring codes 98975, 98984, 98976, 98985, 98977, 98979, 98979, 98980 and 98981 as do not use to validate physician work in the RUC database due to vignette issues due to the uncertainty on who is predominantly providing these services. These services will be reviewed for this flag and via the new technology/new services list after three years of data are available (April 2030).

<u>Osteotomy of Spine (Tab 21)</u>
Anthony DiGiorgio, MD (AANS), Hussein Elkousy, MD (AAOS), Clemens Schirmer, MD (CNS), Karin Swartz, MD (NASS)

In the Proposed Rule for 2025, CPT codes 22210, 22212, 22214 and 22216 were nominated as potentially misvalued services for the following reasons (1) incorrect global period; (2) incorrect inpatient days; (3) incorrect intra-service work description; (4) overvalued intra-service times; (5) changed surgical practice; and (6) incorrect use of posterior osteotomy codes. CMS notes that these services were last reviewed in 1995 and all but CPT code 22216 lacks a description of work or vignettes describing the typical patient. CMS also noted that bundling of these services may be necessary, such as CPT code 22210 and 22600 *Arthrodesis, posterior or posterolateral technique,*

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single interspace; cervical below C2 segment. The nominator suggested two options to address this concern: (1) developing add-on codes to differentiate between the number of vertebral segments involved in the osteotomy procedure and whether it occurs in the cervical, thoracic, or lumbar regions; and (2) removing the current posterior osteotomy codes and incorporating osteotomies into new deformity fusion codes, both with and without osteotomy. CMS indicated in the Notice of Proposed Rulemaking for 2025 that this code family be considered as potentially misvalued.

The RUC considered these services at the January 2025 RUC meeting. The specialty societies submitted a detailed letter (attached) on why they disagreed with issues identified by the nominator. The specialties indicated that there is no evidence that these services have an incorrect global period. They also noted that the nominator did not provide a comprehensive list of literature to support the claim that incorrect inpatient days are represented in these services, provided no evidence that the intra-service time is incorrect or that these services have changed in adults.

The specialty societies did not conduct a survey of these codes and requested that the RUC refer this issue to the CPT Editorial Panel for revision. The specialties will consult with pediatric spine surgeons specializing in scoliosis surgery to submit a CPT Code Change Application (CCA). **The RUC recommends that CPT codes 22210-22216 be referred to the September 2025 CPT Editorial Panel meeting for the CPT 2027 cycle.**

<u>Arthrodesis – Great Toe (Tab 22)</u>
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Jonathan Feibel, MD (AOFAS), Susan M. Walsh, DPM (APMA)

In April 2024, the Relativity Assessment Workgroup (RAW) identified CPT code 28750 on the different performing specialty from survey screen, 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 RAW noted that when this service was last valued in 1995, podiatry, which now performs 57% of this service was not involved in the survey. The RUC recommended that 28750 be surveyed for January 2025 with the applicable family of services. Code 28755 was added as part of the code family, which was valued by the Harvard Studies and never RUC surveyed.

Compelling Evidence
The specialty societies provided evidence that incorrect assumptions were made in the previous valuation of the service, as documented: a previous valuation excluded a specialty that currently provides a plurality of the service. For CPT code 28750, the RAW confirmed the survey conducted in 1995 did not include podiatry, currently the dominant provider of the procedure. For CPT code 28755, the Harvard study did not include podiatrists and was reviewed by only nine general orthopaedic surgeons. Additionally, there is evidence that incorrect assumptions were made in the previous valuation of the service, as documented: a flawed mechanism or methodology used in the previous valuation. For CPT code 28750, the survey used for the first Five-Year Review in 1995 did not specify the different components of preservice time (evaluation, positioning, scrub/dress/wait) and therefore underestimated pre-service work and time as documented by the current survey. The 1995 survey instrument also did not accurately capture post-operative work (discharge management and specific levels of office visits but instead asked only for total post-operative time). For CPT code 28755, the Harvard study did not survey pre- or post-service work or time and instead estimated time based on an algorithm. Additionally, no positioning time was assigned, and post-operative work was underestimated based on this methodology. **The RUC determined there was compelling evidence that incorrect assumptions were made in the previous valuation of these services because a specialty that currently provides the plurality of these services was not included in the survey. Further, a flawed methodology for valuation was used.**

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28750 ***Arthrodesis, great toe; metatarsophalangeal joint***
The RUC reviewed the survey results from 166 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 8.75 appropriately accounts for the work required to perform this service. The RUC recommends 33 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, 15 minutes immediate post-service time, 0.5-99238, 1-99212, 2-99213 and 1-99214, which totals 249 minutes. The pre-service positioning was increased above the standard 3 minutes to 10 minutes to account for padding of bony prominences, positing and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging equipment during surgery. Seven to 10 days after surgery, the first postoperative office visit would involve a moderate level of medical decision making (99214). The problem addressed (moderate) at the encounter is side effects of treatment (big toe arthrodesis) for a chronic illness (severe arthritis) where the patient is not at the treatment goal of a fused stable joint that allows pain-free weight-bearing ambulation, return to wearing shoes, and return to activities of daily living. There is moderate risk for patient management that involves medication management, including multi-modal pain medications (ie, narcotic and nonnarcotic) and assessment of continued need for DVT prophylaxis. Treatment risk also involves assessment of when and how the patient can begin weight-bearing (ie, appropriate DME). The next two post-operative office visits involve a low level of medical decision making (99213). The patient is still not at treatment goal and decisions about nonnarcotic paid management and techniques for mitigation of pain and swelling are addressed. Ambulation DME is assessed and changed as needed. There is minimal data to review and treatment risk is low. The last postoperative office visit in the 90-day global period involves straightforward medical decision making as the patient is assessed for progress of joint fusion and advancement of pain-free and weight-bearing ambulation. *For more information, all post-operative visits and levels are outlined in specific detail in the summary of recommendation (SOR) form attached.*

Although the survey intra-service time has decreased slightly by 15 minutes, the total time increased by 12 minutes due to the prior underestimation of pre-and post-operative work. In addition, the pre-service time was previously underestimated and the value of the post-operative work has significantly increased since the last review. The RUC noted that 28750 requires more physician time and work to perform because the metatarsophalangeal joint is larger, more complex anatomically, and often involves more extensive soft tissue manipulation due to its location at the base of the big toe, where greater forces are exerted during walking compared to the smaller more peripheral joints such as with 28755 and the interphalangeal joint.

The RUC compared the surveyed code to the top key reference code 28297 *Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method* (work RVU = 9.29, 75 minutes intra-service time and 256 minutes total time). The RUC noted that this reference code chosen by almost 60% of the respondents required 15 minutes more intra-service time and 7 minutes more total time and was appropriately valued higher than the survey code even though a majority of the respondents indicated that the intensity, complexity, and work of both procedures was the same. The RUC compared the surveyed code to the second top key reference service 28295 *Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal metatarsal osteotomy, any method* (work RVU = 8.57, 60 minutes intra-service time and 241 minutes total time). The RUC noted that both codes require the same intra-service time, but that the intra-service intensity related to fusing a joint was greater and the post-operative work to treat the patient following the fusion was greater. The RUC agreed that the slightly higher work RVU for the surveyed code appropriately accounted for this difference. The RUC also compared the surveyed code to CPT code 27792 *Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed* (work RVU = 8.75, 60 minute intra-service time and 245 minutes

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total time) noting that these services require the same intra-service time, number of post-operative visits and nearly the same total time, thus should be valued the same.

For additional support, the RUC referenced MPC code 21556 *Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 7.66, 60 minutes intra-service time and minutes 234 minutes total time), which requires less total time and post-operative visits and 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, 60 minutes intra-service time and minutes 207 minutes total time), which is somewhat more intense but requires less post-operative visits. These codes appropriately bracket the recommendation for the survey code. The RUC determined that the survey 25th percentile work value of 8.75 appropriately places CPT code 28750 relative to other services in the Medicare Physician Payment Schedule (MFS) based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 8.75 for CPT code 28750.**

28755 ***Arthrodesis, great toe; interphalangeal joint***
The RUC reviewed the survey results from 160 orthopaedic surgeons and podiatrists and determined that the survey 25th percentile work RVU of 7.50 appropriately accounts for the work required to perform this service. The RUC recommends 33 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 45 minutes intra-service time, 15 minutes immediate post-service time, 0.5-99238, 1-99212, 2-99213 and 1-99214, which totals 234 minutes. The pre-service positioning was increased above the standard 3 minutes to 10 minutes to account for padding of bony prominences, positing and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging equipment during surgery. The RUC noted that the survey intra-service time has increased by 1 minute from the Harvard study estimate; however, the total time has increased by over 60 minutes supporting the compelling evidence of a flawed methodology for this service during the Harvard study . Seven to 10 days after surgery, the first post-operative office visit would involve a moderate level of medical decision making (99214). The problem addressed (moderate) at the encounter is side effects of treatment (big toe arthrodesis) for a chronic illness (severe arthritis) where the patient is not at the treatment goal of a fused stable joint that allows pain-free weight-bearing ambulation, return to wearing shoes, and return to activities of daily living. There is moderate risk for patient management that involves medication management, including multi-modal pain medications (ie, narcotics and nonnarcotic) and assessment of continued need for DVT prophylaxis. Treatment risk also involves assessment of when and how the patient can begin weight-bearing (ie, appropriate DME). The next two post-operative office visits involve a low level of medical decision making (99213). The patient is still not at treatment goal and decisions about nonnarcotic paid management and techniques for mitigation of pain and swelling are addressed. Ambulation DME is assessed and changed as needed. There is minimal data to review and treatment risk is low. The last post-operative office visit in the 090-day global period is straightforward medical decision making as the patient is assessed for progress of joint fusion and advancement of pain-free and weight-bearing ambulation. *For more information, all post-operative visits and levels are outlined in specific detail in the summary of recommendation (SOR) form attached.*

The RUC compared the surveyed code to the top key reference code 28298 *Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal phalanx osteotomy, any method* (work RVU = 7.75, 60 minutes intra-service time and 225 minutes total time) and the second top key reference service 28291 *Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant* (work RVU = 8.01, 50 minutes intra-service time and 215 minutes total time) and determined that the surveyed service requires slightly less physician work even though the total times for all three codes were similar.

For additional support, the RUC referenced MPC code 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, 45 minutes intra-service time and minutes 161

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minutes total time), which requires less total time and less intense post-operative work, thus valued lower and 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46, 60 minutes intra-service time and minutes 246.5 minutes total time), which is somewhat more intense but requires less post-operative visits, thus valued higher than 28755. The RUC determined that the survey 25th percentile work value of 7.50 appropriately places CPT code 28755 relative to other services in the Medicare Physician Payment Schedule (MFS) based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 7.50 for CPT code 28755.**

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 as podiatry is the dominant specialty but was not included in the prior RUC survey or Harvard study. Moreover, several supply and equipment items were missing that are necessary for these procedures. For example, no drills, saws, or screws were included. Similarly, although a suction machine was included, there were no suction machine supplies. A mobile C-arm was also not included, but is standard to confirm bone alignment and fusion work throughout the procedure as described in the description of work. Compelling evidence was accepted based on change in specialty and errors in prior evaluation.

The PE Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. In response to an inquiry on whether a power table or power chair is used for the procedure, the specialties confirmed that EF031 *table, power* is typical. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies**

<u>Temporary Female Intraurethral Valve-Pump (Tab 23)</u>
Seth Cohen, MD (AUA), Jonathan Kiechle, MD (AUA)

In the CMS Medicare Physician Payment Schedule (MFS) Proposed Rule for 2025, under the Valuation of Specific Codes section II.E., CMS indicated that an interested party nominated two Category III CPT codes 0596T and 0597T as potentially misvalued. The nominator expressed concern about variability and inadequate Medicare Administrative Contractor (MAC) pricing for the contractor-priced services. This year, the nominator newly informed CMS that their analysis of national payment rates showed that in most CMS jurisdictions, not only are these codes misvalued, but in most cases, they are not valued at all, with payment schedule amounts in most CMS jurisdictions at or near zero dollars. CMS noted that the Agency continues to hear concerns about these payment inconsistencies for CPT codes 0596T and 0597T. As a result, CMS is recommending that the MACs establish more consistency in pricing, enabling the appropriate inclusion of the Vesiflo system in the code's PE valuation. Therefore, for CY 2025, CMS encouraged interested parties to provide more accurate and appropriate cost data, along with additional information regarding work RVU, work time, indicators, and utilization estimates for the MACs.

In the Final Rule for 2025, CMS indicated that they would add pricing for three new supplies related to these services: 1) inFlow Measuring Device priced at $140 (SD370), 2) inFlow Valve-Pump Device priced at $495 (SD371) and 3) inflow Activator Kit priced at $1,250 (SD372). **The RUC recommends that CMS change the device names to be generic descriptions, rather than brand names.**

The specialty societies noted that they conducted a targeted survey of American Urological Association members and those from a vendor list. Even with the targeted survey only 19 responses each were received for both 0596T and 0597T. The RUC noted that it will flag these services for review by the Relativity Assessment Workgroup after three years of data are available.

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0596T ***Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement***

The RUC reviewed the survey results from 19 urogynecologists and determined that the survey 25th percentile work RVU of 2.43 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 20 minutes intra-service time and 10 minutes immediate post-service time. An additional 8 minutes of pre-evaluation time over the pre-time package is necessary for the physician to instruct the patient on the use of the activation device and ask the patient to demonstrate the ability to manipulate the device. Urine culture results are reviewed to ensure the procedure can safely be performed. Urodynamic results are reviewed to ensure the patient is appropriate for placement of the device. This device is typically used in medically complex patients with severe voiding dysfunction necessitating an increase in pre-service evaluation time compared to the package time. Positioning time is 5 minutes as indicated by the survey respondents and consistent with the additional time for positioning in dorsal lithotomy or urological procedures pre-service package.

The intraurethral valve pump is indicated for women with urinary retention. The device consists of an intraurethral valve pump housed in a silicone biocompatible housing. When the device is in place, it completely obstructs the urethra. The patient or patient's caregiver must then use a battery-operated magnet-activated remote control held over the pubis to activate the device and empty the bladder. If the device malfunctions or the patient does not use the device appropriately, the patient will remain in urinary retention with the concomitant risks associated with high volume retention, including the development of hydronephrosis and renal dysfunction. During initial placement, a catheter is placed into the bladder, and the bladder is filled. The physician then places a sizing device to determine which of the nine different size options for urethral valve pumps should be placed, based on the patient's urethral length. Following measurement, the appropriate valve pump is selected and placed. The pump has prongs that secure the device at the bladder neck to prevent device loss from the urethra and a tab that sits outside the urethra to prevent device migration into the bladder. The device must then be adjusted for comfort to avoid pain within the bladder and introitus. The activator device is then used to verify that the device empties the bladder appropriately.

The RUC compared the surveyed code to the top key reference code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70, 20 minutes intra-service time and 60 minutes total time) and determined that the surveyed code is slightly less intense and complex to perform, therefore appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU = 3.20, 21 minutes intra-service time and 58 minutes total time) and determined that the surveyed service is much less intense and complex to perform, thus valued lower. For additional support, the RUC referenced MPC code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 2.82, 25 minutes intra-service time and 56 minutes total time), which is more intense and complex, thus valued higher and 36514 *Therapeutic apheresis; for plasma pheresis* (work RVU = 1.81, 20 minutes intra-service time and 64 minutes total time), which is less intense and complex, thus valued lower.

The RUC also referenced other supportive services such as 31572 *Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral* (work RVU = 3.01, 20 minutes intra-service time and 60 minutes total time) and 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* (work RVU = 2.50, 20 minutes intra-service time and 60 minutes total time), both which require the same intra-service time and similar total time. The RUC determined that the survey 25th percentile work value of 2.43 appropriately places CPT code 0596T relative to other

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services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 2.43 for CPT code 0596T.**

0597T ***Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement***
The RUC reviewed the survey results from 19 urogynecologists and determined that the survey 25th percentile work RVU of 1.33 was slightly high in relation to the initial insertion, and recommends a work RVU of 1.05 for 0597T. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time and 6 minutes immediate post-service time. Positioning time is 5 minutes as indicated by the survey respondents and consistent with the additional time for positioning in dorsal lithotomy or urological procedures pre-service package. The RUC recommends a crosswalk to CPT code 11730 (work RVU=1.05, 10 minutes intra-service time and 33 minutes total time).

This procedure describes the work of replacing the female urethral valve that was inserted with 0596T. The valve requires replacement every 29 days. After the patient is positioned in dorsal lithotomy and local anesthesia is provided, the device is firmly grasped and removed, and the new intraurethral valve pump is placed through the urethra, securing the device tines at the bladder neck and the prong outside the urethra to keep the device comfortably in place.

The RUC compared the surveyed code to the top key reference code 51710 *Change of cystostomy tube; complicated* (work RVU = 1.35, 15 minutes intra-service time and 42 minutes total time) and determined that the surveyed code requires less time to perform, therefore appropriately valued lower. The RUC compared the surveyed code to the second top key reference service 51705 *Change of cystostomy tube; simple* (work RVU = 0.90, 10 minutes intra-service time and 32 minutes total time) and determined that the surveyed service is more intense and complex to perform, requires slightly more total time, thus is valued higher. For additional support, the RUC referenced MPC codes 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66, 5 minutes intra-service time and 21 minutes total time), which requires less time, intensity and complexity to perform, thus valued lower and 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 10 minutes intra-service time and 27 minutes total time) which is more intensity and complexity to perform, thus valued higher.

The RUC also referenced other supportive services such as 64420 *Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level* (work RVU = 1.08, 10 minutes intra-service time and 34 minutes total time) and 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU = 1.20, 10 minutes intra-service time and 32 minutes total time) both which require the same intra-service time and similar total time. The RUC determined that the survey a work value of 1.05 appropriately places CPT code 0597T relative to other services in the Medicare Physician Payment Schedule (MFS) based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 1.05 for CPT code 0597T.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made a single modification to remove supply SD372 *inFlow Activator Kit* from the replacement code 0597T because this kit is only used for the initial insertion. The PE Subcommittee also acknowledged that the pre-service clinical staff time for 000- and 010-day global codes is presumed to be zero and agreed with the specialty's use of the pre-service time package for "Use of Clinical Staff for Endoscopy".

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The PE Subcommittee acknowledged the recently priced (for 2025) high-cost supply input, SD372 *inFlow Activator Kit,* as recommended for code 0596T. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
Although the technology to perform these services has been available for a decade, very few physicians perform these services. These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC after three years of data are available (April 2030).

RUC Flag
The RUC will flag codes 0596T and 0597T as Do Not Use to Validate Physician Work - Low survey response, since the survey responses of 19 were below the 30 response threshold. The Relativity Assessment Workgroup will review these services after three years of data are available (April 2030). Specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision.

X. Research Subcommittee (Tab 24)

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

The Research Subcommittee did not have a separate general policy meeting which coincided with the January 2025 RUC meeting. The Subcommittee last met on October 7, 2024, to review specialty society requests pertaining to RUC surveys for the January 2025 meeting. On the October 7th call, the Research Subcommittee reviewed and approved proposed vignettes, custom survey templates, draft reference service lists, targeted survey sample methodology requests and discussed RUC crosswalks and reference code guidelines.

The RUC approved the Research Subcommittee Report.

XI. Practice Expense Subcommittee (Tab 25)

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

High-Cost Supplies
The CY 2025 Medicare Physician Payment Schedule includes 85 medical supply items currently embedded in codes with a purchase price of more than $500. These high-cost medical supplies represent $1.32 billion dollars in direct costs for the 2025 Medicare Physician Payment Schedule and 19 percent of all direct practice expense medical supply costs in the non-facility setting.

A joint CPT and RUC workgroup to address the issue of high-cost disposable supplies and their impact on coding and valuation was created after the September 2024 RUC meeting. Comprised of four CPT Editorial Panel members and four RUC members, the Workgroup on Coding and Valuation Issues Related to High-Cost Disposable Supplies was charged with identifying potential solutions and alternatives to present to the Centers for Medicare & Medicaid Services (CMS).

The Workgroup drafted a letter to CMS to reframe the high-cost disposable supply issue, including the importance of verifying the cost of these supplies on an annual basis, and convened an open virtual meeting on December 16, 2024, to review and provide comment on the draft. Almost 150

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participants were on the call to discuss the issue of high-cost supplies in the Medicare Physician Payment Schedule.

The PE Subcommittee supported the letter as drafted by the CPT/RUC Joint Workgroup on Coding and Valuation Issues Related to High-Cost Disposable Supplies which continues to call on CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using Healthcare Common Procedure Coding System (HCPCS) supply codes. Additionally, the letter encourages CMS to review and re-price high-cost medical supplies on an annual basis.

The PE Subcommittee recommended that the RUC and CPT Editorial Panel review and approve the draft letter at their respective upcoming meetings to submit to CMS by its February 10, 2025, deadline.

New Angio Supply Pack
The PE Subcommittee considered Tab 6 Lower Extremity Revascularization and a request from the specialties to create a new pack for angiography services. The specialty societies recommended the PE Subcommittee consider creating an angio pack with the following components:

Angio Pack Contents		**Corresponding Supply list components**				**$ 68.26**
10 cc syringe	SC051	syringe 10-12ml	item	0.21	4	$ 0.84
Bowl, sterile	SJ079	basin, sterile 500cc	item	3.51	2	$ 7.02
gauze	SG055	gauze, sterile 4in x 4in	item	0.19	20	$ 3.80
marker, regular tip	SK075	skin marking pen, sterile (Skin Skribe)	item	1.62	1	$ 1.62
dome cover	SB008	drape, sterile, c-arm, fluoro	item	5.38	1	$ 5.38
blue towels	SB019	drape-towel, sterile 18in x 26in	item	0.47	4	$ 1.88
scalpel	SF007	blade, surgical (Bard-Parker)	item	0.68	1	$ 0.68
back table cover	SB014	drape, sterile, three-quarter sheet	item	3.46	1	$ 3.46
20cc syringe	SC053	syringe 20ml	item	0.83	4	$ 3.32
drape, femoral	SB009	drape, sterile, femoral	item	9.15	1	$ 9.15
medicine cup	SL157	cup, sterile, 8 oz	item	0.58	1	$ 0.58
label sheet	SL198	label, vial	item	0.02	9	$ 0.18
control syringe (lidocaine)	SC051	syringe 10-12ml	item	0.21	1	$ 0.21
scissor	SA027	kit, scissors and clamp	kit	0.82	1	$ 0.82
surgical gowns x 2	SB028	gown, surgical, sterile	item	5.13	2	$ 10.26
18 G needle	SC027	needle, 18-19g, filter	item	0.21	1	$ 0.21

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25 G needle	SC028	needle, 18-26g 1.5-3.5in, spinal	item	9.96	1	$ 9.96
needle counter	SD120	styrofoam block, high density (3in-12in-12in)	item	1.86	1	$ 1.86
towel clamps (plastic disposable)	SD208	towel clamp, plastic	item	0.76	4	$ 3.04
Guidewire bowl	SD171	guidewire bowl w-lid, sterile	Item	3.99	1	$ 3.99

The PE Subcommittee agreed that an angio pack would facilitate the PE process and ensure consistency within the vascular/interventional procedures. The Subcommittee recommended that the RUC approve the creation of a new Angio Pack, as detailed above, for submission to the CMS.

The RUC approved the Practice Expense Subcommittee Report.

XII. Multi-Specialty Points of Comparison (MPC) Workgroup (Tab 26)

Doctor Amr Abouleish, Chair, provided the Multi-Specialty Points of Comparison (MPC) Workgroup to the RUC.

Review of the Service to Sunset off MPC List and Specialty Code Recommendations
The MPC Workgroup members reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list. Participating specialty societies used the MPC submission form to provide a more granular rationale for each code submission. Representatives from specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members noted that the specialty societies should be encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list. The MPC Workgroup reminded the specialty societies that any specialty with 10% or more Medicare utilization for a code should comment on the appropriateness of the addition or deletion of that code.

The MPC Workgroup members agreed to maintain 6 codes and delete 19 codes based on the sunset review, delete another 8 codes, and add 6 codes to the MPC list with justification provided by specialty societies in their recommendations.

Review of Services to Sunset – Recommendation to Maintain Codes on MPC List
In June 2021, the MPC Workgroup recommended identifying and reviewing codes on the MPC list that have not been reviewed in the last 15 years as part of its annual review. This year, there were 25 services on the MPC list that have not been RUC reviewed in the last 15 years. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "maintain" or "delete" these services, along with their supporting rationale.

The American College of Emergency Physicians recommended maintaining 93042 on the MPC list, to which the MPC Workgroup agreed. The American Society of Anesthesiologists recommended maintaining 62350, 63661, 64480 and 64484 on the MPC list, to which the MPC Workgroup agreed. The American Society of Plastic Surgeons (ASPS) and the American Academy of Dermatology originally submitted a recommendation to maintain 15576 on the MPC list. Prior to the meeting, the two specialty societies decided to change their recommendation and instead recommended it sunset

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off the MPC list. The Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and ASPS recommended maintaining 21556, to which the MPC Workgroup agreed. AAO-HNS and ASPS also recommended maintaining 25071 on the MPC list but decided to withdraw their recommendation and let the code sunset off the MPC list at the table. ASPS also recommended maintaining 26113 and 26116 on the MPC list but decided to withdraw their recommendation and let the codes sunset off the MPC list at the table.

The remaining 15 services set to sunset off the MPC list did not receive any specialty society response to maintain, thus the Workgroup agreed to delete them from the MPC list.

The MPC Workgroup recommends maintaining the following 6 services: 93042, 64484, 64480, 63661, 62350 and 21556. The MPC Workgroup recommends deleting the following 19 services: 92285, 90935, 90945, 46930, 94011, 64483, 90937, 64479, 51102, 25071, 64708, 26116, 26113, 25116, 54530, 15576, 21025, 53445 and 54410.

MPC List Services Deletions

The MPC Workgroup annually solicits the specialty societies for codes that should be added to or deleted from the MPC list. There were 8 services recommended for deletion from the MPC list by the American Urological Association. The MPC Workgroup clarified that 7 of those codes including 55700, 38571, 52601, 52649, 55840, 55866 and 55845 should have been previously removed due to the fact that these services were under review at the September 2024 RUC meeting and thus is appropriate they be deleted. The MPC agreed that those 7 codes, as well as 53850, should be deleted from the MPC list.

The MPC Workgroup recommends deleting the following eight services: 55700, 53850, 38571, 52601, 52649, 55840, 55866 and 55845.

MPC List Additions

The MPC Workgroup annually solicits the specialty societies for codes that should be added to or deleted from the MPC list. There were 6 services recommended for addition to the MPC list by the American Academy of Audiology and the American Speech-Language-Hearing Association. The MPC Workgroup agreed with the addition of these services.

The MPC Workgroup recommends adding the following six services: 92542, 92517, 92653, 92519, 92626, and 92652.

Other Business

The MPC Workgroup discussed several additions and clarifications to the MPC History, Process and Criteria document. This included the addition of language in the list of the MPC Workgroup's responsibilities to more clearly articulate MPC protocol and screens as such (see bold underlined text):

The MPC workgroup shall maintain the responsibility of updating the MPC, using the established process, including:

- **AMA staff will remove codes from the MPC when they are identified to be surveyed at a RUC meeting. Specialties may renominate a code to be added to the MPC list when the code valuation is published in the CMS Final Rule.**

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- Review the codes on the current MPC list that have been valued more than 15 years prior and identify those to be retained according to the new criteria. **Once a code has been identified and reviewed, it will be reviewed every other year after for as long as it is on the MPC list.**

- Review MPC list for deficiencies or problems, then craft strategies to resolve.

- The MPC list will require continuous review and refinement with codes added and deleted from specialty society nominations and MPC Workgroup review.

Additionally, the Workgroup discussed revising the language in the Absolute Criteria section of the MPC History, Process and Criteria document and striking the word "should" from all three criteria. In their discussion, the Workgroup agreed that this revision would better distinguish Absolute Criteria from the Suggested Criteria section and provide a more rigorous standard for what it means for a code to meet the Absolute Criteria. The following revisions are listed below (see bold underlined text):

Absolute Criteria:

- The codes ~~**should**~~ have current work RVUs that the specialty(s), RUC, and CMS accept as valid.
- Any specialty(s) that perform(s) greater than 10% of the total utilization or greater than 10,000 billing instances of the service ~~**should have**~~ has the right to consider the appropriateness of the inclusion of the service on the MPC list. The MPC Workgroup will review that request in consultation with the performing specialty(s), which shall be offered the opportunity to comment, and make a recommendation to the RUC for final determination.
- Any code included in the MPC list ~~**should have**~~ has gone through the RUC survey process and have RUC approved time.

The Workgroup agreed that these revisions be made during the January 2025 RUC meeting so that the MPC History, Process and Criteria document is prepared for the April 2025 RUC meeting.

The RUC approved the Multi-Specialty Points of Comparison (MPC) Workgroup Report.

XIII. Relativity Assessment Workgroup (Tab 27)

Doctor Matthew Grierson, Chair, provided the report of the Relativity Assessment Workgroup (RAW) noting that the Workgroup reviewed five action plans and finalized review of the Hyperbaric Oxygen Under Pressure issue as outlined in the full report.

Do Not Use to Validate Physician Work Flag Screen

The primary agenda item discussed was regarding the RUC database flagging system. At the April 2024 RUC meeting, a RUC member inquired about the RAW reviewing codes that are flagged in the RUC database as "Do Not Use to Validate Physician Work" (DNU) to see if these codes warrant a screen for re-review. Two RUC members supported re-visiting codes that are flagged in the RUC database. This item was referred to the RAW for further discussion.

In September 2024, the five groupings of rationale for the "do not use" flag were identified.

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

The Workgroup noted that providing a more granular description of the "do not use" flags in the RUC database would be helpful. The Workgroup requested that AMA staff work with the Workgroup Chair determine if additional data or screens may be developed based on some parameters for low survey response flagged codes.

"Other" Specific Flag Noted Codes

There are 73 other specific reasons codes were flagged as "do not use", of which 28 codes were flagged due to a low survey response rate. In 2018, the RUC adopted a policy on how to address and monitor codes the RUC reviews that had a survey response rate below the minimum of 30.

> **Proposed at the January 11, 2018, Administrative Subcommittee meeting and approved at the January 10-13, 2018, RUC meeting:**
>
> ***Low Survey Responses/Contractor Pricing***
> **The Administrative Subcommittee reviewed the history of low survey responses and determined that the RUC should not automatically recommend contractor pricing codes that have a low response rate (under 30), but continue its current process and review each unique code set individually.** The Subcommittee indicated that its main concern is that new Category I CPT codes are created when in reality the services are not widely performed and a valid survey with 30 responses is not obtainable. **The Administrative Subcommittee recommends that the RUC flag new Category I services with a survey response below 30 to be reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.**

Therefore, of the 28 codes flagged for a low response rate, 21 are already scheduled to be reviewed by the RAW. There are 7 codes that were flagged prior to the RUC policy and have not been addressed and need to be examined further. Two services, codes 43284 and 43285, were reviewed on the new technology/new services list in April 2024 and were removed from further review on that list**. The Workgroup discussed and recommended that the DNU flag of low survey response codes 43284 and 43285 should remain flagged on the DNU list and an action plan be submitted in April 2025.** The Workgroup noted that the flag for 31605 and 31610 is "do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU."

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Therefore, the Workgroup determined that the flag for 31605 and 31610 be changed to "atypical valuation methodology" however, an action plan should be submitted in April 2025. The Workgroup requested that specialty societies submit an action plan for the three other codes (67255, 67505, and 64400) in April 2025 to address if the DNU flag should remain for these low response rate surveyed codes.

The Workgroup reviewed the remaining 43 "other specific" DNU flagged codes to determine if 1) these codes should remain flagged in the RUC database and 2) if the service should remain flagged, what specific code grouping should be noted in the RUC database. **The Workgroup determined that all 43 other specific DNU flagged codes should remain flagged in the RUC database and that the three categories "valued by building block", "valued by crosswalk" and "valued by increment" be collectively flagged as "atypical value methodology" instead.**

The Workgroup recommends the following 12 titles for "other specific flags":

1. **Add-On Valued as separately reported**
2. **Anomalous intra-service time**
3. **Co-surgeon service**
4. **Low survey performance rate**
5. **Low survey response**
6. **Low volume code**
7. **Negative IWPUT**
8. **Not surveyed**
9. **Service times not representative**
10. **Survey demonstrated increase, however, no compelling evidence**
11. **Atypical valuation methodology**
12. **Vignette issue**

The detailed flag descriptions for these 73 services are in the attached DNU Codes spreadsheet and should be noted in the RUC database as such.

The Workgroup discussed the low survey response flagged codes and changed CPT code 64400 to be flagged as "atypical value methodology" instead. The Workgroup determined that the remaining 25 low survey response flagged codes will continue to be reviewed under the scheduled timeline and process already established.

The Workgroup discussed that it should establish a process to review all other specific flagged codes after a number of years after they are flagged. **The Workgroup determined that it should reexamine the 48 other specific flagged codes that are currently flagged in detail by reviewing an action plan from the specialty societies. The Workgroup will spread this review over the next three RAW meetings, first looking at the top 1/3 or 16 codes with the highest Medicare utilization. The Workgroup will review action plans to determine if the top 16 DNU specific flagged codes should be resurveyed, revised at CPT, maintained with the flag or the flag removed. The goal will be to find a way to resolve the issue that led to the flag, if possible.** The Workgroup noted if a code is on the new technology/new services list already scheduled for review, that those codes be maintained on that list and address the new technology/new service and DNU flag at the same time.

The Workgroup determined that codes flagged as DNU in the future and categorized within one of the "other specific flags" above be systematically reviewed by the Relativity Assessment Workgroup after three years of data are available to determine if the codes should be resurveyed, revised at CPT, maintained with the flag or the flag removed. The goal will be to find a way to resolve the issue that led to the flag, if possible. The Workgroup noted if a code is on

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another screen already scheduled for review, that those codes be maintained on that list and address both that screen and the DNU flag at the same time.

The Workgroup reviewed the four other groupings for the remaining 311 DNU flagged codes and concluded the rationale was clear and these flags should remain without further review by the Workgroup.

1. **Reallocation of physician time components for PE purposes**
2. **Surveyed physician time has not been validated by the RUC**
3. **Molecular pathology codes, not covered on MFS**
4. **CMS increased independent of RUC review.**

The detailed flag descriptions for these 311 services are in the attached DNU Codes spreadsheet and should be noted in the RUC database as such.

The RUC approved the Relativity Assessment Workgroup Report.

XIV. Health Care Professionals Advisory Committee (HCPAC) Review Board (Tab 28)

Dr. Leisha Eiten, Alternate Co-Chair, provided the report of the HCPAC Review Board.

HCPAC Review Board Co-Chair & Alternate Co-Chair Nominations & Election
The HCPAC Review Board conducted an election for the positions of Co-Chair and Alternate Co-Chair at their January 2025 meeting. Leisha Eiten, AuD, CCA-A, was nominated for the position of HCPAC Review Board Co-Chair. Korinne Van Keuren, DNP, MS, RN and Mary Walsh-Sterup, OTR/L were nominated for the position of HCPAC Review Board Alternate Co-Chair. All parties were nominated by their respective specialty societies. **The HCPAC elected Leisha Eiten, AuD, CCA-A, Co-Chair and Korinne Van Keuren, DNP, MS, RN, Alternate Co-Chair. The new terms for both positions will begin March 1, 2025 and conclude in February 28, 2027.**

Relative Value Recommendations for CPT 2026
Remote Monitoring (98986, 98978)
Stephen Gillaspy, PhD (APA) and Scott Sperling, PsyD (APA)

In April 2022, the Relativity Assessment Workgroup (RAW) identified code 99457 as part of a screen for codes that were surveyed by one specialty but are now typically performed by a different specialty. In September 2022, the RAW reviewed an action plan on this service and recommended it be reviewed in two years (2021-2022 data) after utilization has stabilized after the pandemic. In April 2024, the RAW noted that 99457, along with the codes 99453, 99454 and 99458 were on the new technology/new services list for review. The specialty societies indicated that a CPT code change application (CCA) was submitted for May 2024 to review the Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) codes (which may require surveying of these codes) and to refer this issue to CPT Assistant regarding correct coding of this family of services. The RAW recommended that this code family be reviewed at the next RAW meeting in September 2024 to summarize what has occurred at the CPT Editorial Panel. The RAW noted that if this family was not addressed via the upcoming CPT process the RAW should discuss when it would be surveyed. In September 2024, the RAW noted that a CCA for remote monitoring was reviewed at the September 2024 CPT meeting, which included codes 99453-99458. The RUC noted that 99453-99458 needed to be surveyed because the utilization of 99457 increased and the primary specialties who perform these services did not participate in the survey.

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In September 2024, the CPT Editorial Panel added one code and made code revisions to report remote physiologic monitoring device supply for 2-15 days and 16-30 days within a 30-day period to report remote physiologic monitoring parameters; created one new code and code revisions to report remote physiologic monitoring treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; added three remote therapeutic monitoring device supply codes to report respiratory, musculoskeletal and cognitive behavioral therapy for 2-15 days and 16-30 days within a 30-day period; created one new code and made code revisions to report remote therapeutic monitoring treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; and revised the "Digitally Stored Data Services/Remote Physiologic Monitoring" guidelines, "Remote Physiologic Monitoring Treatment Management Services" guidelines, "Remote Therapeutic Monitoring Services" guidelines, and the "Remote Therapeutic Monitoring Treatment Management Services" guidelines. **The RUC HCPAC Review Board will submit practice expense recommendations for CPT codes 98986 and 98978.**

98986 ***Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period***
98978 ***Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period***
Codes 98986 and 98978 describe remote therapeutic monitoring for cognitive behavior therapy. The RUC HCPAC agreed with the specialty societies request for no clinical staff time and one new input for a digital therapeutic device. The RUC HCPAC recommended that a digital therapeutic device be added to the CMS direct PE medical supplies listing. The digital therapeutic device is an FDA-authorized product that helps healthcare providers conduct remote therapeutic monitoring to track patients' therapeutic progress and symptom status. These services and related digital therapeutic devices are for monitoring only. It is a $50 monthly fee, per patient. This is supported by the invoices submitted. **The RUC HCPAC and Practice Expense Subcommittee recommend the addition of a supply input as submitted by the professional organization and will forward the invoices to CMS for pricing.**

New Technology/New Services
CPT codes 98986 and 98978 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

Multi-Specialty Points of Comparison (MPC) List Updates
The HCPAC Review Board reviewed the addition of CPT codes 92517, 92519, 92568, 92652, and 92653 to the HCPAC Multi-Specialty Points of Comparison (MPC) list. **After review of the suggested criteria, the HCPAC voted to accept the addition of CPT codes 92517, 92519, 92568, 92652, and 92653 to the HCPAC MPC list given that it met the majority of absolute and suggested criteria.**

The HCPAC Review Board reviewed the proposed deletion of CPT code 92540 to the HCPAC Multi-Specialty Points of Comparison (MPC) list. **After review of the proposal, the HCPAC voted to delete CPT code 92540 from the HCPAC MPC list given that the code was last reviewed in April 2009.**

The RUC filed the HCPAC Review Board report.

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XV. Rotating Seat Elections (Tab 29)

Administrative Subcommittee
Doctor James Waldorf, Chair, informed the RUC that the Administrative Subcommittee communicated over email in December 2024.

Review Rotating Seat Election Rules and Candidates Nominated (Tab 29)
The Subcommittee reviewed the nomination for the internal medicine rotating seat, Luke Barre, MD from the American College of Rheumatology (ACRh), and nominations for the any other rotating seat, Anne Miller, MD from the American Society of Surgery for the Hand (ASSH) and John T. Thompson, MD from the American Society of Retina Specialists (ASRS).

The Administrative Subcommittee also reviewed the RUC rotating seat election rules. The Subcommittee noted that two candidates are nominated for the any other rotating seat, therefore one ballot will be issued and the candidate with the majority of votes will be elected to the seat. The Subcommittee noted that "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote," as is the case with the current internal medicine rotating seat election.

The RUC approved the Administrative Subcommittee report.

The elections occurred Saturday, January 18, 2025.

Luke Barre, MD from the American College of Rheumatology (ACRh), was elected to the RUC's internal medicine rotating seat.

Anne Miller, MD from the American Society of Surgery for the Hand (ASSH), was elected to the RUC's any other rotating seat.

The term for these rotating seats is two years, beginning in March 2025 and ending in February 2027 with the provision of final recommendations to CMS.

XVI. New Business (Tab 30)

- A RUC member inquired about the efficacy of RUC pre-facilitation. Several members spoke in support of pre-facilitation and the continued improvement of structure and related efficiency during the RUC meeting, especially for complex large tabs.

- A RUC member discussed artificial intelligence (AI) and the emerging and evolving technology for radiology and other services. The member further expressed concern about AI code change applications at CPT and RUC that may lead to large reviews of families of existing services. It was acknowledged that future discussion of AI as it relates to the CPT and RUC processes will be ongoing. The RUC Chair reminded members that the CPT Editorial Panel has created the Digital Medicine Coding Caucus to discuss these topics.

- A RUC member requested clarification on the functionality and useability of the RUC survey. AMA staff clarified that the survey has been tested by expert economists and statisticians, and it has been refined numerous times by the RUC Research Subcommittee. **AMA staff via the Research Subcommittee will conduct a demonstration of the survey instrument for committee members and seek further input.**

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- A RUC member stated that when new Category I codes with low volume and limited physicians performing the service, it is often difficult to survey for appropriate valuation. A member suggested that the CPT Editorial Panel should track codes that do not reach the necessary survey threshold to see if it is worthwhile to revise CPT's widespread use criteria. The CPT Representative to the RUC stated that this information will be taken back to the Panel for consideration. Note: At this RUC meeting, there was only one issue that involved new technology Category I codes where the specialty was unable to obtain 30 survey responses.

The RUC adjourned at 5:27 PM PT on Saturday, January 18, 2025.

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AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
Research Subcommittee Report
Monday, October 7, 2024

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

I. Superficial Radiation Therapy (77436-77439): Review Request for two Reference Service Lists (RSLs) and Targeted Survey Sample Methodology

American Academy of Dermatology Association
American Society of Radiation Oncology
American College of Radiation Oncology

In September 2024, the CPT Editorial Panel created four codes to report surface radiation therapy; the Panel also deleted two existing codes. The American Academy of Dermatology Association (AADA), the American Society of Radiation Oncology (ASTRO), and the American College of Radiation Oncology (ACRO) requested Research review of two proposed reference service lists (RSLs) and a targeted survey sampling methodology.

The Research Subcommittee first reviewed the proposed RSL for XXX global code 77436. The Subcommittee noted that CPT code 77280 should be removed, as this code just had an action plan presented to the RAW in September 2024 for a change in specialty screen. Dermatologists were formerly using 77280 to report superficial radiation treatment therapy and the presence of this code on an RSL for 77436 would cause issues. Separately, Subcommittee members noted that code 77285 may also have the same issues and the societies should consider removing 77285 from their RSL as well. A Subcommittee member also suggested for the societies to consider adding code 88380.

The Subcommittee next reviewed the separate RSL for ZZZ code 77439. Subcommittee members suggested that, if possible, some of the codes that have not been reviewed in more than 10 years could be replaced with more recently reviewed codes. Code for potential addition that were offered were 17315, 10004, 10006 and 10008.

The Subcommittee next discussed the survey sampling request with the presenters. The societies requested to use a targeted list of physicians from the CMS Medicare Physician & Other Practitioners Lookup Tool (https://data.coms.gov) who report the current SRT code 77401 (Radiation treatment delivery, superficial and/or ortho voltage, per day) and 0394T (High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed). ASTRO and ACRO noted that they planned to also do a random sample of their relevant member sections. The chair noted that what ASTRO and ACRO were requesting did not require Research review and approval. AADA requested to only use the targeted sample methodology. The Subcommittee did not approve AADA's request to only use a targeted sample. Instead the Subcommittee approved for AADA to use this targeting sample methodology only if its accompanied by a random sample of either there general membership or one of their member sections as defined in the Research guidelines and requirements document.

II. Endoscopic Sleeve Gastroplasty (ESG) (43889): Review Request for RSL, Use of Vendor List and Direct Practice Expense Information

American College of Gastroenterology
American Gastroenterological Association
America Society of Gastrointestinal Endoscopy
American Society for Metabolic and Bariatric Surgery
Society of American Gastrointestinal and Endoscopic Surgeons

In September 2024, the CPT Editorial Panel created one new code describing transoral gastric restrictive procedures through an endosurgical approach. The American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), the America Society of Gastrointestinal Endoscopy (ASGE), the American Society for Metabolic and Bariatric Surgery (ASMBS) and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) requested Research review of a proposed RSL and approval to use a targeted sample.

The Subcommittee first discussed the RSL with the presenters. The Subcommittee strongly recommended for the societies to remove CPT code 52649 from the RSL as this code was just surveyed for the September 2024 RUC meeting. A Subcommittee member inquired if gastroenterologists would be sufficiently familiar with a lot of the major surgical procedures that were included on the RSL. However, it was noted that these procedures were included in part because many would be familiar to SAGES and ASMBS survey respondents and also as there are relatively few 090-day global GI procedure codes.

The Subcommittee next discussed the survey sampling request with the presenters. The Subcommittee approved for the societies to use the vendor list if it is also accompanied by either a simple random sample or a random sample of applicable subset(s) for each participating society. ASMBS inquired whether their society's Flexible Endoscopy Committee met the definition for a random sample of applicable subset, as per the rules in the Research Subcommittee Guidelines and Requirements document. The Subcommittee noted that it did not as the ASMBS Flexible Endoscopy Committee has fewer than 30 members and is appointed by the ASBMS board. ASBMS noted that they would instead use on of their membership interest groups that is relevant to endoscopic services and the Subcommittee confirmed that this would be appropriate.

III. Radiation Oncology Treatment Delivery (77402, 77407, 77412 and 77417): Review Request for Proposed Custom Practice Expense Survey and Proposed Vignette

American Society for Radiation Oncology
American College of Radiation Oncology

In September 2024, the CPT Editorial Panel revised three codes and related guidelines to consolidate services for radiation treatment delivery. Three existing codes were deleted and 77417 and 77387 were identified as a family codes.

The American Society for Radiation Oncology (ASTRO) and the American College of Radiation Oncology (ACRO) requested Research review of a proposed custom practice expense survey template. The presenters noted that, historically, CMS and the AMA RUC/Practice Expense (PE) subcommittee require specialty societies to conduct practice expense surveys for services with stand-alone procedure times and equipment over $1M. (Federal Register / Vol. 77, No. 146). Therefore, the societies submitted a proposed practice expense survey for the recently revised radiation treatment delivery family of services. The attached draft survey tool was developed using principles from the (1) February 2014 practice expense survey for the same services (2) recent E/M practice expense survey and (3) current PE guidelines.

As part of the discussion, one Subcommittee member pointed out a typo, where rows 64, 65 and 81 were referring to the incorrect location of the vignettes in the spreadsheet. The societies noted that they would

correct this. Subcommittee members also asked why line 82 of the spreadsheet was asking the respondent to provide the specific make and model of their Linac machine. The presenters noted that purpose of that question was to inform which invoices they should try to attain to submit to the Practice Expense Subcommittee. Subcommittee members asked whether clinical activities on lines 40 *Prepare room, equipment, supplies* and line 41 *Prepare, set-up and start IV, initial positioning and monitoring of patient* overlap. It was later confirmed that these are the standard PE spreadsheet clinical activities, so no change was warranted. **The Research Subcommittee approved the custom PE survey template.**

The Research Subcommittee discussed the proposed vignette for PE only code 77417, which does not currently have a vignette in the RUC database. **The Research Subcommittee approved the vignettes as submitted:**

> **CPT Code 77417** ***Therapeutic radiology port image(s)***
> **Research-Approved Vignette:** 50-year-old female presents with an infiltrating ductal carcinoma of the right breast metastatic to the right axillary nodes. Radiation treatment is delivered to the breast and regional lymph nodes (separately reportable).

IV. Percutaneous Electrical Nerve Field Stimulation (64567): Review Request for RSL

American Academy of Pediatrics
American Gastroenterological Association

In September 2024, the CPT Editorial Panel created one new code to describe procedures for percutaneous electrical nerve field stimulation of cranial nerves. The American Academy of Pediatrics and the American Gastroenterological Association requested Research review of a proposed XXX global RSL.

The Subcommittee discussed the proposed RSL and made a general observation that the proposed version is heavy on imaging codes. The Subcommittee recommended to replace some of these codes with services that would be more relevant to the survey respondents. Subcommittee members offered several codes that could be used in lieu of some of the imaging codes that are currently on the proposed RSL: 99212, 99231, 99238 and 99214. A suggestion was also made to include some reference codes at the low end of the RVU range (below the 0.81 RVUs of the current lowest RVU reference code).

V. Percutaneous Interlaminar Lumbar Decompression (62287, 62330 and 62331): Review Request for RSL, Proposed Vignettes and General Survey Plan

American Society of Anesthesiologists
American Society of Regional Anesthesia and Pain Medicine

In September 2024, the CPT Editorial Panel created two new codes to describe percutaneous interlaminar lumbar decompression with partial removal of the ligamentum flavum. CPT code 62287 was also included in the tab as a family code. The American Society of Anesthesiologists and the American Society of Regional Anesthesia and Pain Medicine requested research review of proposed vignette changes and a proposed RSL. The societies also provided other informational only items as a reference that did not require Research approval.

The Subcommittee discussed the proposed RSL and made several recommendations. The Subcommittee noted that Code 52601 was just surveyed and reviewed at the September 2024 RUC meeting and should be removed. Similarly, CPT code 27279 was revised at September 2024 CPT Editorial Panel meeting, will be surveyed for January 2025 RUC meeting, and should also be removed from this RSL. Subcommittee members noted that the RSL RVU range is too narrow on the low end and could use

several reference codes below 9.1 RVUs. A Subcommittee member also suggested that some of the codes that had values lower than the original RUC recommendation could be removed and replaced with codes 69729, 47562, 57288 and 49000.

The societies requested for the Research Subcommittee to approve their plan to not survey CPT code 62287 and for them to instead request for that service to be deleted. Research noted that this item was instead a decision for the RUC and noted that this situation as it is outside of the Subcommittee's purview.

The Research Subcommittee discussed the proposed vignette for codes 62331 and 62332. The presenter noted that the societies believe this additional sentence is necessary to make clear to surveyees that 62331 and 62332 were created by CPT to report a minimally invasive method to percutaneously remove portions of the ligamentum flavum attached to the lamina and debulk the ligamentum flavum. Codes 62331 and 62332 should not be reported for open decompression procedures (laminectomy/laminotomy). **The Research Subcommittee approved the vignettes as submitted:**

62331 ***Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one interspace, lumbar***
Proposed vignette: A 67-year-old male is diagnosed with symptomatic lumbar spinal stenosis with neurogenic claudication unresponsive to conservative therapy. Imaging demonstrates thickened ligamentum flavum with resultant stenosis of the spinal canal at L3-L4. The patient does not require immediate open decompression. The patient undergoes a percutaneous thinning of the ligamentum flavum.

62332 ***Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)***
Proposed vignette: A 70-year-old female is diagnosed with symptomatic lumbar spinal stenosis with neurogenic claudication unresponsive to conservative therapy. Imaging demonstrates thickened ligamentum flavum with resultant stenosis of the spinal canal at L3-L4 and L4-L5. The patient does not require immediate open decompression. After performing thinning of the L3-L4 ligamentum flavum (separately reported), an additional thinning of the L4-5 ligamentum flavum is performed. [Note: This is an add-on service. Only consider the additional work related to treatment of one additional interspace.]

VI. Cystourethroscopy (52443): RSL Review
Irreversible Electroporation of Tumors (55877): RSL Review
Temporary Female Intraurethral Valve-Pump (0596T, 0597T): Vignette Review

American Urological Association

In September 2024, the CPT Editorial Panel created one new code to describe cystourethroscopy, with initial transurethral anterior prostate commissurotomy. The American Urological Association (AUA) will be surveying this code and requested Research review of a proposed RSL. The Subcommittee noted that this RSL looked well-constructed and did not have any specific recommendations for adding or removing any codes. A subcommittee member noted that some of the codes are relatively low volume, though that is likely fine, unless there are higher volume alternative reference codes that could be used as replacements.

In September 2024, the CPT Editorial Panel created two new code to describe percutaneous irreversible electroporation ablation of 1 or more tumors in the liver (47384) and prostate (55877) respectively. It was noted that AUA will be surveying only code 55877 and the American College of Radiology and the Society of Interventional Radiology would only be surveying codes 47384. As there is no specialty overlap and there are different practice patterns, there was agreement that it is fine that 47384 is being surveyed as a 000-day global code and that 55877 is being surveyed as a 090-day global code. Separately, AUA had submitted a proposed 090-day global RSL for the Subcommittee's review for code 55877. The Subcommittee noted that code 54438 is being deleted for CPT 2025 and should be removed from the RSL. The Subcommittee also recommended for the societies to consider removing codes 27120, 54438 and 50250. A subcommittee member suggested for the societies to consider adding code 15738 and also to fill in any gaps potentially created by the removal of the other codes (if other valid reference codes are available).

CMS indicated that in the CY 2024 Proposed Rule, an interested party nominated two Category III CPT codes 0596T and 0597T as potentially misvalued. The nominator expressed concern about variability and inadequate Medicare Administrative Contractor (MAC) pricing for the contractor-priced services. In the CY2025 proposed rule, CMS noted that the Agency continues to hear concerns about these payment inconsistencies for CPT codes 0596T and 0597T. As a result, CMS is recommending that the MACs establish more consistency in pricing, enabling the appropriate inclusion of the device in the code's PE valuation. Therefore, for CY 2025, CMS encourages interested parties to provide more accurate and appropriate cost data, along with additional information regarding work RVU, work time, indicators, and utilization estimates for the MACs. The RUC will review these services at the January 2025 RUC meeting. The American Urologic Association will be surveying these codes and submitted a request for Research approval of proposed vignettes.

The Subcommittee discussed the originally submitted vignettes and noted that they included detailed descriptions of the procedure and the typical site of service that were not commiserate with the typical format for a vignette. The Subcommittee noted that being this prescriptive could potentially be leading to the survey respondents, so they made several modifications. **The Research Subcommittee approved the vignettes as follows:**

> **0596T** ***Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement***
> **Research-Approved Vignette:** A 65-year-old woman has a medical disorder causing inability to void spontaneously. She lacks manual dexterity to perform self-catheterization. She wishes to avoid the infection risk associated with an indwelling catheter. A temporary intraurethral valve-pump is inserted.
> **0597T** ***Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement***
> **Research-Approved Vignette:** A 65-year-old woman has a medical disorder causing inability to void spontaneously. She underwent temporary intraurethral valve-pump insertion 29 days ago. She presents for replacement of the device.

VII. Arthrodesis – Great Toe (28750, 28755): Proposed Vignettes

American Academy of Orthopaedic Surgeons
American Podiatric Medical Association
American Orthopaedic Foot & Ankle Society

The American Podiatric Medical Association (APMA), American Academy of Orthopaedic Surgeons (AAOS), and American Orthopaedic Foot & Ankle Society (AOFAS) will be surveying codes 28750 and 28755 for the January 2025 RUC meeting. The specialties noted that CPT code 28750 has a vignette that

was used in 1995 during the first 5-year review and that CPT code 28755 is a Harvard valued code that does not have a vignette.

The Subcommittee discussed the proposed vignettes with the presenters. A point was made that the top diagnosis code grouping in the RUC database for both services was M20 *Acquired deformities of fingers and toes* (71% of 28750 Medicare claims and 48% of Medicare 28755 claims). One of the presenters noted that the top ICD-10 subgrouping for M20 for code 28750 is M202 Hallux rigidus at 33% of all Medicare claims and that is a form of arthritis. When taking that into account, the diagnoses codes in the Medicare claims data for CPT code 28750 do typically show a patient with arthritis. Separately, one of the presenters noted that these procedures are performed on patients with many different kinds of arthritis and inquired if it would be appropriate to remove the word "degenerative" from both vignettes. The Subcommittee confirmed that that change would be appropriate if the societies elected to make that change. **The Research Subcommittee approved the vignettes as follows:**

28750 Arthrodesis, great toe; metatarsophalangeal joint
Research-Approved Vignette: A 50-year-old female with severe ~~degenerative~~ arthritis of the big toe metatarsophalangeal joint undergoes arthrodesis of this joint.
28755 Arthrodesis, great toe; interphalangeal joint
Research-Approved Vignette: A 50-year-old female with severe ~~degenerative~~ arthritis of the big toe interphalangeal joint undergoes arthrodesis of this joint.

VIII. Remote Monitoring (request for code 99091 only): Proposed Vignette

American College of Cardiology
American College of Physicians
American Academy of Family Physicians
American Nurses Association

The American College of Cardiology, the American College of Physicians, the American Academy of Family Physicians and the American Nurses Association submitted a proposed vignette for CPT code 99091 for the Research Subcommittee's consideration. The societies noted that the legacy vignette for the code is not in alignment with RUC preferred form as it is rather long and includes descriptions of work which should not be included in a vignette. **The Research Subcommittee approved the vignettes as submitted:**

***99091* Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days**
Research-Approved Vignette: A 72-year-old female patient with poorly controlled hypertension undergoes remote physiologic data collection.

IX. Thoracic Branch Endograft Services (33880, 33881, 33882, 33883, 33886 and 35602): Custom Survey Request

American Association for Thoracic Surgery
Society of Interventional Radiology
Society for Thoracic Surgeons
Society for Vascular Surgery

The Society for Vascular Surgery, the American Association for Thoracic Surgery, the Society of Interventional Radiology and the Society for Thoracic Surgeons requested to modify the 090-day survey tool for the upcoming Thoracic Branched Endograft RUC survey to include language regarding pre-planning physician time. The proposed modifications were similar to the modifications made to the EVAR survey tool for the January 2017 meeting and the Iliac Branched Endograft survey tool for the January 2019 meeting. The specialty noted these procedures are complex and require extensive planning, often more than 24 hours prior procedure, in order to be performed successfully. The current survey tool precludes the survey respondent from being able account for this pre-planning time.

A Research Subcommittee member asked whether the principal care management (PCM) codes 99424 and 99425 could be used to report thoracic branch endograft procedure pre-planning work. The societies noted that PCM, by definition, is for chronic care management and thoracic branch endograft pre-planning would not fall under chronic care. Thoracic Branch Endograft procedures are an acute/one time surgery. PCM codes 99424 and 99425 have zero utilization for interventional radiology, vascular surgery and cardiothoracic surgery in the RUC database also.

The societies noted that Thoracic Branched Endograft pre-planning involves time to review the aneurysm anatomy on CT angiogram, confirm the suitability of the anatomy for EVR, make a large number of aortic diameter and center-line length measurements, review available endograft sizes and develop an operative plan that will successfully treat the pathology at hand. Additional measurements are needed as well. This service is provided after evaluation in the office, but more than 24 hours prior to the procedure.

The Research Subcommittee approved the custom template with some editorial changes to the physician time question and the physician time question's background definition/instructions.

Background for Question 2: Surgery (090 global period)

Pre-service period
The pre-service period includes pre-operative endograft planning (regardless of when the planning occurs) as well as other physician services provided from the day before the operative procedure until the time of the operative procedure. The latter may include the following:

- Hospital admission work-up.

- The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.

- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other "non-skin-to-skin" work in the OR.

…

Question 2

How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your time for the survey code on the front cover. *(Refer to definitions.)*

Note: Do not include time for work related to another service, procedure, or evaluation and management code that is separately reportable.

Question 2a) THORACIC ENDOGRAFT PLANNING

Include the total of all thoracic endograft planning time spent prior to the procedure regardless of the day(s) that the planning occurred. Do not include any thoracic endograft planning time in 2b or 2c below.

Pre-service planning time: _____ minutes

Question 2b) Day preceding procedure (in minutes) **Survey Code**

Pre-service evaluation time: _____ minutes

Question 2c) Day of procedure (in minutes)

Pre-service evaluation: _____ minutes
Pre-service positioning time: _____ minutes
Pre-service scrub, dress, wait time: _____ minutes
Intra-service time: _____ minutes
Immediate post-service time* _____ minutes

AMA/Specialty Society RVS Update Committee **Tab 25**
Practice Expense Subcommittee
January 15-16, 2025

Members Present: Scott Manaker, MD, PhD, (Chair), Amy Aronsky, DO, Gregory Barkley, MD, Michael Booker, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal Cohen, MD, David Han, MD, Mollie MacCormack, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, Donald Selzer, MD, Thomas Weida, MD, Adam Weinstein, MD, and Lawrence Simon, MD (CPT Resource)

I. High-Cost Supplies

A joint CPT and RUC workgroup to address the issue of high-cost disposable supplies and their impact on coding and valuation was created after the September 2024 RUC meeting. Comprised of four CPT Editorial Panel members and four RUC members, the Workgroup on Coding and Valuation Issues Related to High-Cost Disposable Supplies was charged with identifying potential solutions and alternatives to present to the Centers for Medicare & Medicaid Services (CMS).

The CY 2025 Medicare Physician Payment Schedule includes 85 medical supply items currently embedded in codes with a purchase price of more than $500. These high-cost medical supplies represent $1.32 billion dollars in direct costs for the 2025 Medicare Physician Payment Schedule and 19 percent of all direct practice expense medical supply costs in the non-facility setting.

The Workgroup drafted a letter to CMS to reframe the high-cost disposable supply issue, including the importance of verifying the cost of these supplies on an annual basis, and convened an open virtual meeting on December 16, 2024, to review and provide comment on the draft. Almost 150 participants were on the call to discuss the issue of high-cost supplies in the Medicare Physician Payment Schedule.

The Practice Expense (PE) Subcommittee supported the letter as drafted by the CPT/RUC Joint Workgroup on Coding and Valuation Issues Related to High-Cost Disposable Supplies which continues to call on **CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using Healthcare Common Procedure Coding System (HCPCS) supply codes. Additionally, the letter encourages CMS to review and re-price high-cost medical supplies on an annual basis.**

The PE Subcommittee recommends that the RUC and CPT Editorial Panel review and approve the draft letter at their respective upcoming meetings to submit to CMS by its February 10, 2025, deadline.

II. Other Business

The PE Subcommittee considered Tab 6 *Lower Extremity Revascularization* and a request from the specialties to create a new pack for angiography services. As described in the PE SOR, the specialty societies are recommending the PE Subcommittee consider creating an angio pack with the following components:

Angio Pack Contents		**Corresponding Supply list components**				**$ 68.26**
10 cc syringe	SC051	syringe 10-12ml	item	0.21	4	$ 0.84
Bowl, sterile	SJ079	basin, sterile 500cc	item	3.51	2	$ 7.02
gauze	SG055	gauze, sterile 4in x 4in	item	0.19	20	$ 3.80
marker, regular tip	SK075	skin marking pen, sterile (Skin Skribe)	item	1.62	1	$ 1.62
dome cover	SB008	drape, sterile, c-arm, fluoro	item	5.38	1	$ 5.38
blue towels	SB019	drape-towel, sterile 18in x 26in	item	0.47	4	$ 1.88
scalpel	SF007	blade, surgical (Bard-Parker)	item	0.68	1	$ 0.68
back table cover	SB014	drape, sterile, three-quarter sheet	item	3.46	1	$ 3.46
20cc syringe	SC053	syringe 20ml	item	0.83	4	$ 3.32
drape, femoral	SB009	drape, sterile, femoral	item	9.15	1	$ 9.15
medicine cup	SL157	cup, sterile, 8 oz	item	0.58	1	$ 0.58
label sheet	SL198	label, vial	item	0.02	9	$ 0.18
control syringe (lidocaine)	SC051	syringe 10-12ml	item	0.21	1	$ 0.21
scissor	SA027	kit, scissors and clamp	kit	0.82	1	$ 0.82
surgical gowns x 2	SB028	gown, surgical, sterile	item	5.13	2	$ 10.26
18 G needle	SC027	needle, 18-19g, filter	item	0.21	1	$ 0.21
25 G needle	SC028	needle, 18-26g 1.5-3.5in, spinal	item	9.96	1	$ 9.96
needle counter	SD120	styrofoam block, high density (3in-12in-12in)	item	1.86	1	$ 1.86
towel clamps (plastic disposable)	SD208	towel clamp, plastic	item	0.76	4	$ 3.04
Guidewire bowl	SD171	guidewire bowl w-lid, sterile	Item	3.99	1	$ 3.99

The PE Subcommittee agrees that an angio pack would facilitate the PE process and ensure consistency within the vascular/interventional procedures. The Subcommittee recommends that the RUC approve the creation of a new Angio Pack, as detailed above, for submission to the CMS.

III. Practice Expense Recommendations for CPT 2026

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

Tab	Title	PE Input Changes	Consent Calendar
4	Hip and Pelvis Arthrodesis Revisions	No Survey	X
5	Thoracic Branch Endograft Services	(1) Modification	
6	Lower Extremity Revascularization	Modifications	
7	Endoscopic Sleeve Gastroplasty	Standard 90-day global inputs recommended	X
8	Irreversible Electroporation of Tumors	No Changes	
9	Cystourethroscopy	No Changes	
10	Percutaneous Interlaminar Lumbar Decompression	Standard 90-day global inputs recommended	X
11	Laminotomy – Repair of Disc Defect	No Direct PE Inputs recommended – Facility-only services	X
12	Baroreflex Activation Therapy	No Changes	
13	Percutaneous Electrical Nerve Field Stimulation	No Changes	
14	Percutaneous Decompression of Median Nerve	Modifications	
15	Coronary Atherosclerotic Plaque Assessment	(1) Modification	
16	Radiation Oncology Treatment Delivery	No Changes	
17	Superficial Radiation Therapy	(1) Modification	

Tab	Title	PE Input Changes	Consent Calendar
18	Combination COVID-19 Vaccine Administration	Affirming Sept. 2023 RUC Recommendations (90480) No Direct PE Inputs recommended (90481)	X
19	Scalp Cooling Services	Modifications	
20	Remote Monitoring	Modifications	
21	Osteotomy of Spine	Referral to the CPT Editorial Panel	X
22	Arthrodesis – Great Toe	No Changes	
23	Temporary Female Intraurethral Valve-Pump	(1) Modification	
28	HCPAC Review Board – Remote Monitoring	No Changes	

AMA
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February 10, 2025 DRAFT

TBD Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: High-Cost Disposable Supplies

Dear Administrator TBD,

On behalf of the Current Procedural Terminology (CPT) Editorial Panel and the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), we urge the Centers for Medicare & Medicaid Services (CMS) to address the escalating issue of high-cost disposable supplies within the Medicare physician payment system.

For two decades, **the RUC has strongly recommended that CMS separately identify and pay for high-cost disposable supplies (i.e., priced more than $500) using appropriate Healthcare Common Procedure Coding System (HCPCS) supply codes.** CMS has been reluctant to implement this recommendation. In the most recent Final Rule (CMS-1807-F), CMS stated that it is "aware of the issues with the current practice expense (PE) methodology caused by very expensive supply and equipment items, and this is a subject that we may consider for future rulemaking alongside other updates to the PE methodology."

The CY 2025 Medicare Physician Payment Schedule includes 85 medical supply items currently embedded in codes with a purchase price of more than $500. These high-cost medical supplies represent $1.32 billion dollars in direct costs for the 2025 Medicare Physician Payment Schedule and 19 percent of all direct practice expense medical supply costs in the non-facility setting. We contend that the outsized impact that high-cost disposable supplies have within the current practice expense relative value unit (PE RVU) methodology must be addressed immediately as the influx of new technology and high-cost supplies continues. **This has become a pressing issue for physician practices and a potential impediment to our patients who could benefit from access to these new technologies.** For example, there are 12 CPT codes where the total non-facility payment does not cover the purchase price of the high-cost supply input. There are another eight codes where the PE payment alone does not cover the high-cost supply. We are extremely concerned about the increasing impact on Medicare beneficiaries including impeding access to new technology and innovative care if payment does not cover invoice cost. *Please see the attached analysis of high-cost supplies over $500.*

The payment accuracy concerns not only involve a concern that practices be compensated fully for the cost of the supply. In other instances, the supply item may be inaccurately priced as CMS does not update these prices frequently. Additionally, the current PE methodology not only accounts for a large amount of direct practice expense for high-cost supplies but also allocates an anomalously large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. This methodology derives code-level indirect practice expense in part from code-level direct practice expense inputs, including high-cost disposable supplies. **When CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service, which is subsidized by the broader specialty and all other physician and qualified healthcare professionals.**

Importantly, as required by law, it is CMS' responsibility to ensure the accurate pricing of the high-cost supply items. Accurate pricing of the 85 high-cost supplies is critical and should be based on a transparent process, where items are annually reviewed and updated. Under the current payment methodology, these supplies are priced at one point in time and then bundled within the overall physician payment for this service, without further review. High-cost disposable medical supplies that reflect new technology may experience pricing changes within the first six months to one year after a wider release into the market. **We strongly recommend and encourage CMS to review and re-price medical supplies, priced above $500, on an annual basis.**

Moreover, CMS has excluded cast and splint supplies from the practice expense database for the CPT codes for fracture management and cast/strapping application procedures since 2000. These supplies can be separately billed using HCPCS codes Q4001 through Q4051. Efficiencies could potentially be realized if the high-cost supplies were pulled out of the physician payment schedule and pricing was negotiated.

We appreciate your attention to resolving the high-cost disposable supply issue and ensuring payment and pricing accuracy in the Medicare physician payment system. If you have any questions regarding this letter, please contact Sherry Smith at Sherry.Smith@ama-assn.org.

Sincerely,

Christopher L. Jagmin, MD
Chair, CPT Editorial Panel

Ezequiel Silva III, MD
Chair, AMA/Specialty Society RVS Update Committee

Enclosure

cc: Perry Alexion, MD
Lindsey Baldwin
Arkaprava Deb, MD
Mitali Dayal
Edith Hambrick, MD
Ryan Howe
Michael Soracoe
Gift Tee
Emily Yoder

DRAFT

DESCRIPTION	Supply_Code	CPT_Code	Short Description	Sum of Aggregate NF Global & TC Cost
atherectomy device (Spectronetics laser or Fox Hollow)	SD253			$ 224,857,014
Reentry device (Frontier, Outback, Pioneer)	SD255			$ 178,072,434
Varithena (foam)	SD324			$ 104,810,825
Embolic Protection Device Spider FX (EV3, documentation available)	SD256			$ 93,492,974
subcutaneous cardiac rhythm monitor system	SA127			$ 85,809,158
Venaseal (glue)	SD323			$ 74,018,945
covered stent (VIABAHN, Gore)	SD254			$ 73,024,602
human amniotic membrane allograft mounted on a non-absorbable se	SD248			$ 67,870,281
Kyphoplasty kit, first fracture	SA111			$ 46,152,803
IVUS catheter	SD304			$ 44,749,893
kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	SA106			$ 38,462,438
Esketamine (84 mg vial)	SH110			$ 24,763,185
Urolift Implant and implantation device	SD291			$ 24,623,375
LC Beads (2mL vial)	SF058			$ 24,534,059
Biodegradable Material Kit - PeriProstatic	SA126			$ 23,598,435
Detachable coil	SF056			$ 21,220,414
Cryoablation handpiece and 2 canisters (one per side)	SD358			$ 18,028,337
Trial lead kit	SD280			$ 16,604,698
venous stent system	SD340			$ 15,377,250
Trial lead array	SD281			$ 11,097,100
FISH pre-treatment kit	SL261			$ 9,557,602
Radiofrequency Stylus / wand	SD357			$ 9,280,830
TULSA-PRO Disposable Kit	SA136			$ 9,086,351
stent, self expanding 2-5 mm XPERT (Abbott)	SD266			$ 8,996,917
kit, for percutaneous thrombolytic device (Trerotola)	SA015			$ 8,850,863
VivAer Stylus	SD352			$ 8,047,650
Kyphoplasty kit, additional fracture	SA112			$ 7,131,742
kit, eustachian tube procedure	SA134			$ 6,635,010
Hysteroscopic tissue removal device	SF059			$ 4,890,746
stent, vascular, deployment system, Cordis SMART	SA103			$ 4,862,463
kit, Rezum delivery device	SA128			$ 4,407,860
plate, surgical, reconstruction, left, 5 x 16 hole	SD191			$ 4,183,156
kit, CVA catheter, tunneled, with subcut port	SA011			$ 3,302,891
Esketamine (56 mg vial)	SH109			$ 2,353,533
catheter, RF ablation, endoscopic	SC103			$ 1,777,500
Claravein Kit	SA122			$ 1,496,361
Voice Augmentation Gel	SJ090			$ 1,391,459
Ellipsys Vascular Access Catheter	SD351			$ 1,342,933
tray, RTS applicator (MammoSite)	SA087			$ 1,232,947
iTIND device	SD366			$ 1,046,915
stent, balloon, implantable	SD299			$ 939,982
implantable interstitial glucose sensor	SD334			$ 876,000
Absorabable nasal implant and delivery device	SA133			$ 843,885
plasma LDL adsorption column (Liposorber)	SD186			$ 811,691
kit, transurethral microwave thermotherapy	SA036			$ 727,670
Wavelinq EndoAVF catheters	SD350			$ 672,000
IVC filter	SD267			$ 567,744
probe, cryoablation, renal	SD233			$ 450,535
probe, radiofrequency, 3 array (StarBurstSDE)	SD109			$ 402,864
EECP compression equipment package	SD341			$ 373,765
SmartPill capsule	SD272			$ 351,091
3C patch system	SD343			$ 232,020
Kit, probe, cryoablation, prostate (Galil-Endocare)	SA099			$ 232,000
kit, vertebroplasty (LP2, CDO)	SA039			$ 219,328
human amniotic membrane allograft	SD247			$ 214,595
laser tip, diffuser fiber	SF030			$ 181,456
kit, stent, urethral, prostatic, insertion tool and surveyor	SA101			$ 154,727
kit, transurethral needle ablation (TUNA)	SA037			$ 131,400
hysteroscope, ablation device	SD177			$ 114,763
kit, PICC with subcut port	SA025			$ 106,291
kit, pleural catheter insertion	SA077			$ 90,325
EECP electrical equipment package	SD342			$ 84,993
Dorsal SI Joint Arthrodesis Implant	SD356			$ 80,500
kit, photopheresis procedure	SA024			$ 69,948
kit, probe, radiofrequency, XIi-enhanced RF probe	SA100			$ 57,033
Renessa probe	SD245			$ 39,723
kit, capsule, ESO, endoscopy w-application supplies (ESO)	SA094			$ 37,346
kit, locatable guide, ext. working channel, w-b-scope adapter	SA097			$ 37,114
RF Electrodes 18 Gauge 70 mm Length	SD368			$ 32,598
strut, replacement, dynamic external fixation	SD240			$ 27,273
stent, GORE VIATORR TIPS Endoprosthesis	SD238			$ 27,138
Viabil covered biliary stent	SD313			$ 24,892
intrastromal corneal ring	SA120			$ 21,755
probe, cryoablation (Visica ICE 30 or 40)	SD232			$ 6,861
probe, endometrial cryoablation (Her Option)	SD215			$ 5,180
catheter, balloon, lacrimal	SD220			$ 4,339
catheter, balloon, thermal ablation (Thermachoice)	SD018			$ 3,813
catheter, CVA, system, tunneled w-port, dual (LifeSite)	SD221			$ 3,500
catheter, intradiscal (spineCATH)	SD222			$ 2,760
RFA Handpiece, sterile (Sonata)	SD361			$ 2,500
Optilume DCB, guidewire, and inflation device	SD359			$ 2,245
ORBERA Intragastric Balloon System (balloon, placement catheter and	SD348			$ 1,850
PillCam COLON capsule	SD346			$ 1,250
kit, hysteroscopic tubal implant for sterilization	SA075			$ 1,178
tray, scoop, fast track system	SA091			$ 750
Grand Total				**$ 1,320,314,616**

CPT_Code	Short Description	Most Recent RUC Review Date	Supply_Code	DESCRIPTION	Unit_of_ Measure	Purchase_Price	Non_Fac_ Quantity	Non_Fac_Cost	2023 Medicare Frequency (from CY2025 Final Rule): Non-Facility Global & TC Only	Aggregate NF Global & TC Cost	CY 2025 Non-Fac PE RVU	CY2025 Non-Facility Practice Expense Payment
33285	Insj subq car rhythm mntr	2017-04	SA127	subcutaneous cardiac rhythm monitor system	item	$ 5,033	1	$ 5,033	17,051	$ 85,809,158	115.73	$ 3,743
55881	Ablt trurl prst8 tis thrm us	2023-09	SA136	TULSA-PRO Disposable Kit	item	$ 8,967	1	$ 8,967	841	$ 7,540,171	252.08	$ 8,154
55882	Ablt trurl prst8 tis trnsdcr	2023-09	SA136	TULSA-PRO Disposable Kit	item	$ 8,967	1	$ 8,967	172	$ 1,546,180	259.18	$ 8,384
55874	Tprnl plmt biodegrdabl matrl	2017-01	SA126	Biodegradable Material Kit - PeriProstatic	item	$ 2,965	1	$ 2,965	7,959	$ 23,598,435	78.46	$ 2,538
37239	Open/perq place stent ea add	2013-04	SD340	venous stent system	item	$ 1,750	1	$ 1,750	1,929	$ 3,375,750	44.98	$ 1,455
36836	Prq av fstl crtj uxtr 1 acs	2022-01	SD351	Ellipsys Vascular Access Catheter	item	$ 7,379	1	$ 7,379	182	$ 1,342,933	220	$ 7,116
0448T	Remvl insj impltbl gluc sens		SD334	implantable interstitial glucose sensor	item	$ 3,000	1	$ 3,000	109	$ 327,000	84.86	$ 2,745
37234	Revsc opn/prq tib/pero stent	2010-04	SD266	stent, self expanding 2-5 mm XPERT (Abbott)	item	$ 3,308	1	$ 3,308	89	$ 294,384	94.85	$ 3,068
53865	Cysto insj dev ischmc rmdlg	2024-01	SD366	iTIND device	item	$ 2,973	1	$ 2,973	352	$ 1,046,915	84.49	$ 2,733
58563	Hysteroscopy ablation	2016-01	SD177	hysteroscope, ablation device	item	$ 1,945	1	$ 1,945	59	$ 114,763	53.82	$ 1,741
58580	Transcrv abltj utrn fibrd rf	2023-01	SD361	RFA Handpiece, sterile (Sonata)	item	$ 2,500	1	$ 2,500	1	$ 2,500	72.14	$ 2,333
53860	Transurethral rf treatment	2010-04	SD245	Renessa probe	item	$ 2,207	1	$ 2,207	18	$ 39,723	63.46	$ 2,053
52442	Cystourethro w/addl implant	2019-01	SD291	Urolift Implant and implantation device	item	$ 875	1	$ 875	23,017	$ 20,139,875	23.35	$ 755
36482	Endoven ther chem adhes 1st	2017-01	SD323	Venaseal (glue)	item	$ 1,495	1	$ 1,495	49,511	$ 74,018,945	43.12	$ 1,395
0446T	Insj impltbl glucose sensor		SD334	implantable interstitial glucose sensor	item	$ 3,000	1	$ 3,000	183	$ 549,000	90.47	$ 2,926
31627	Navigational bronchoscopy	2009-02	SA097	kit, locatable guide, ext. working channel, w-b-scope adapter	kit	$ 977	1	$ 977	38	$ 37,114	28.04	$ 907
37252	Intrvasc us noncoronary 1st	2018-10	SD304	IVUS catheter	item	$ 858	1	$ 858	52,136	$ 44,749,893	24.44	$ 791
58353	Endometr ablate thermal	2000-04	SD018	catheter, balloon, thermal ablation (Thermachoice)	tray	$ 763	1	$ 763	5	$ 3,813	22.21	$ 718
G2083	Visit esketamine, > 56m		SH110	Esketamine (84 mg vial)	item	$ 1,159	1	$ 1,159	21,373	$ 24,763,185	35.44	$ 1,146
22527	Idet 1 or more levels	2006-04	SD222	catheter, intradiscal (spineCATH)	item	$ 1,380	1	$ 1,380	1	$ 1,380	42.45	$ 1,373
58356	Endometrial cryoablation	2004-09	SD215	probe, endometrial cryoablation (Her Option)	item	$ 1,295	1	$ 1,295	4	$ 5,180	40.21	$ 1,301
36566	Insert tunneled cv cath	2003-04	SD221	catheter, CVA, system, tunneled w-port, dual (LifeSite)	item	$ 1,750	2	$ 3,500	1	$ 3,500	108.68	$ 3,515
32550	Insert pleural cath	2004-04	SA077	kit, pleural catheter insertion	kit	$ 551	1	$ 551	106	$ 58,381	17.78	$ 575
27278	Arthrd si jt prq wo tfxj dev	2023-01	SD356	Dorsal SI Joint Arthrodesis Implant	item	$ 11,500	1	$ 11,500	7	$ 80,500	356.28	$ 11,524
G2082	Visit esketamine 56m or less		SH109	Esketamine (56 mg vial)	item	$ 772	1	$ 772	3,047	$ 2,353,533	24.76	$ 801
53855	Insert prost urethral stent	2009-02	SA101	kit, stent, urethral, prostatic, insertion tool and surveyor	kit	$ 512	1	$ 512	302	$ 154,727	16.76	$ 542
36465	Njx noncmpnd sclrsnt 1 vein	2017-01	SD324	Varithena (foam)	item	$ 3,195	0.33	$ 1,054	82,166	$ 86,631,722	33.74	$ 1,091
65778	Cover eye w/membrane	2023-01	SD248	human amniotic membrane allograft mounted on a non-absorbable	item	$ 1,149	1	$ 1,149	59,069	$ 67,870,281	36.76	$ 1,189
37235	Tib/per revasc stnt & ather	2010-04	SD266	stent, self expanding 2-5 mm XPERT (Abbott)	item	$ 3,308	1	$ 3,308	83	$ 274,538	103.54	$ 3,349
32556	Insert cath pleura w/o image	2012-10	SA077	kit, pleural catheter insertion	kit	$ 551	1	$ 551	52	$ 28,640	18.49	$ 598
50592	Perc rf ablate renal tumor	2005-04	SD109	probe, radiofrequency, 3 array (StarBurstSDE)	item	$ 2,289	1	$ 2,289	57	$ 130,473	72.24	$ 2,337
G0465	Autolog prp diab wound ulcer		SD343	3C patch system	item	$ 771	1	$ 771	301	$ 232,020	25.56	$ 827
91111	Gi trc img intral esophagus	2021-01	SA094	kit, capsule, ESO, endoscopy w-application supplies (ESO)	kit	$ 705	1	$ 705	53	$ 37,346	23.9	$ 773
96440	Chmotx admn plrl cav thrcnts	2008-01 PE Review	SA077	kit, pleural catheter insertion	kit	$ 551	1	$ 551	6	$ 3,305	19.15	$ 619
36466	Njx noncmpnd sclrsnt mlt vn	2017-01	SD324	Varithena (foam)	item	$ 3,195	0.33	$ 1,054	17,242	$ 18,179,103	34.79	$ 1,125
36473	Endovenous mchnchem 1st vein	2017-01	SA122	Claravein Kit	kit	$ 883	1	$ 883	1,694	$ 1,496,361	29.69	$ 960
58565	Hysteroscopy sterilization	2004-04	SA075	kit, hysteroscopic tubal implant for sterilization	kit	$ 1,178	1	$ 1,178	1	$ 1,178	38.91	$ 1,259
G0166	Extrnl counterpulse, per tx	2019-10	SD341	EECP compression equipment package	item	$ 827	0.01	$ 8	45,209	$ 373,765	2.96	$ 96
G0166	Extrnl counterpulse, per tx	2019-10	SD342	EECP electrical equipment package	item	$ 752	0.0025	$ 2	45,209	$ 84,993	2.96	$ 96
37242	Vasc embolize/occlude artery	2013-04	SF056	Detachable coil	item	$ 1,199	5	$ 5,997	2,829	$ 16,964,099	188.61	$ 6,101
52284	Cysto rx balo cath urtl strx	2023-01	SD359	Optilume DCB, guidewire, and inflation device	item	$ 2,245	1	$ 2,245	1	$ 2,245	72.77	$ 2,354
36582	Replace tunneled cv cath	2003-04	SA011	kit, CVA catheter, tunneled, with subcut port	kit	$ 511	1	$ 511	61	$ 31,155	19.23	$ 622
53854	Trurl dstrj prst8 tiss rf wv	2018-01	SA128	kit, Rezum delivery device	item	$ 1,220	1	$ 1,220	3,613	$ 4,407,860	41.31	$ 1,336
91113	Gi trc img intral colon i&r	2021-01	SD346	PillCam COLON capsule	kit	$ 625	1	$ 625	2	$ 1,250	23.04	$ 745
53850	Prostatic microwave thermotx	2018-01	SA036	kit, transurethral microwave thermotherapy	kit	$ 1,000	1	$ 1,000	728	$ 727,670	34.7	$ 1,122
31730	Intro windpipe wire/tube	1992-06	SA091	tray, scoop, fast track system	tray	$ 750	1	$ 750	1	$ 750	27.15	$ 878
52441	Cystourethro w/implant	2019-01	SD291	Urolift Implant and implantation device	item	$ 875	1	$ 875	5,124	$ 4,483,500	31.41	$ 1,016
91112	Gi wireless capsule measure	2012-04	SD272	SmartPill capsule	item	$ 1,258	1	$ 1,258	279	$ 351,091	43.5	$ 1,407
68816	Probe nl duct w/balloon	2015-01	SD220	catheter, balloon, lacrimal	item	$ 542	1	$ 542	8	$ 4,339	21.88	$ 708
65779	Cover eye w/membrane suture	2023-01	SD247	human amniotic membrane allograft	item	$ 835	1	$ 835	257	$ 214,595	31.08	$ 1,005
36561	Insert tunneled cv cath	2003-04	SA011	kit, CVA catheter, tunneled, with subcut port	kit	$ 511	1	$ 511	6,399	$ 3,268,161	21.11	$ 683
53852	Prostatic rf thermotx	2018-01	SA037	kit, transurethral needle ablation (TUNA)	kit	$ 900	1	$ 900	146	$ 131,400	33.21	$ 1,074
60660	Abltj 1/+thyr ndul 1lobe prq	2024-01	SD368	RF Electrodes 18 Gauge 70 mm Length	item	$ 1,995	1	$ 1,995	16	$ 32,598	67.15	$ 2,172
37223	Iliac revasc w/stent add-on	2010-04	SA103	stent, vascular, deployment system, Cordis SMART	kit	$ 804	1	$ 804	527	$ 423,487	30.5	$ 987
31574	Largsc w/njx augmentation	2015-10	SJ090	Voice Augmentation Gel	ml	$ 592	1	$ 592	2,350	$ 1,391,459	24.08	$ 779
37237	Open/perq place stent ea add	2013-04	SD299	stent, balloon, implantable	item	$ 812	1	$ 812	99	$ 80,431	31.39	$ 1,015
30469	Rpr nsl vlv collapse w/rmdlg	2022-01	SD352	VivAer Stylus	item	$ 1,950	1	$ 1,950	4,127	$ 8,047,650	66.58	$ 2,154
37186	Sec art thrombectomy add-on	2005-04	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$ 696	1	$ 696	1,022	$ 711,690	27.9	$ 902
50593	Perc cryo ablate renal tum	2007-04	SD233	probe, cryoablation, renal	item	$ 1,170	2.5	$ 2,926	52	$ 152,129	96.84	$ 3,132
30468	Rpr nsl vlv collapse w/implt	2020-01	SA133	Absorbable nasal implant and delivery device	kit	$ 1,995	1	$ 1,995	423	$ 843,885	68.13	$ 2,204
22526	Idet single level	2006-04	SD222	catheter, intradiscal (spineCATH)	item	$ 1,380	1	$ 1,380	1	$ 1,380	49.39	$ 1,598
36571	Insert picvad cath	2003-04	SA025	kit, PICC with subcut port	kit	$ 718	1	$ 718	145	$ 104,136	29.47	$ 953
32998	Ablate pulm tumor perq rf	2017-01	SD109	probe, radiofrequency, 3 array (StarBurstSDE)	item	$ 2,289	1	$ 2,289	14	$ 32,046	78.12	$ 2,527
88121	Cytp urine 3-5 probes cmptr	2009-10	SL261	FISH pre-treatment kit	kit	$ 579	0.2	$ 116	18,355	$ 2,126,280	11.12	$ 360
31297	Nsl/sins ndsc surg sphn sins	2017-01	SA106	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	kit	$ 2,338	0.5	$ 1,169	885	$ 1,034,565	43.82	$ 1,417
31295	Nsl/sins ndsc surg max sins	2017-01	SA106	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	kit	$ 2,338	0.5	$ 1,169	12,432	$ 14,533,008	43.96	$ 1,422
31242	Nsl/sinus ndsc rf abltj pnn	2023-01	SD357	Radiofrequency Stylus / wand	item	$ 1,950	1	$ 1,950	4,759	$ 9,280,830	68.31	$ 2,210
31243	Nsl/sinus ndsc cryoabltj pnn	2023-01	SD358	Cryoablation handpiece and 2 canisters (one per side)	item	$ 1,883	1	$ 1,883	9,575	$ 18,028,337	66.24	$ 2,143
31296	Nsl/sins ndsc surg frnt sins	2017-01	SA106	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	kit	$ 2,338	0.5	$ 1,169	3,225	$ 3,770,025	44.27	$ 1,432
36563	Insert tunneled cv cath	2003-04	SA011	kit, CVA catheter, tunneled, with subcut port	kit	$ 511	1	$ 511	5	$ 2,554	23.92	$ 774
37238	Open/perq place stent same	2013-04	SD340	venous stent system	item	$ 1,750	1.5	$ 2,625	4,572	$ 12,001,500	89.76	$ 2,903
52647	Laser surgery of prostate	1994-05	SF030	laser tip, diffuser fiber	item	$ 730	1	$ 730	9	$ 6,570	32.55	$ 1,053
88120	Cytp urne 3-5 probes ea spec	2009-10	SL261	FISH pre-treatment kit	kit	$ 579	0.3	$ 174	42,767	$ 7,431,322	15.52	$ 502
58558	Hysteroscopy biopsy	2016-01	SF059	Hysteroscopic tissue removal device	item	$ 721	1	$ 721	6,783	$ 4,890,746	32.44	$ 1,049
36908	Stent plmt ctr dialysis seg	2016-01	SA103	stent, vascular, deployment system, Cordis SMART	kit	$ 804	1	$ 804	1,081	$ 868,670	35.17	$ 1,138
52648	Laser surgery of prostate	1994-05	SF030	laser tip, diffuser fiber	item	$ 730	1	$ 730	240	$ 174,886	33.09	$ 1,070
36522	Photopheresis	2017-01	SA024	kit, photopheresis procedure	kit	$ 864	1	$ 864	81	$ 69,948	37.38	$ 1,209
36583	Replace tunneled cv cath	2003-04	SA011	kit, CVA catheter, tunneled, with subcut port	kit	$ 511	1	$ 511	1	$ 511	26.52	$ 858
22515	Perq vertebral augmentation	2014-04	SA112	Kyphoplasty kit, additional fracture	kit	$ 2,149	1	$ 2,149	3,318	$ 7,131,742	77.33	$ 2,501
31298	Nsl/sins ndsc surg frnt&sphn	2017-01	SA106	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	kit	$ 2,338	1	$ 2,338	8,180	$ 19,124,840	83.19	$ 2,691
36585	Replace picvad cath	2003-04	SA025	kit, PICC with subcut port	kit	$ 718	1	$ 718	2	$ 1,436	33.15	$ 1,072
69705	Nps surg dilat eust tube uni	2020-01	SA134	kit, eustachian tube procedure	kit	$ 2,010	1	$ 2,010	1,084	$ 2,178,840	73.17	$ 2,367
36909	Dialysis circuit embolj	2016-01	SF056	Detachable coil	item	$ 1,199	1	$ 1,199	1,770	$ 2,122,761	48.36	$ 1,564
19296	Place po breast cath for rad	2004-02	SA087	tray, RTS applicator (MammoSite)	item	$ 2,828	1	$ 2,828	436	$ 1,232,947	98.95	$ 3,201
43290	Egd flx trnsorl dplmnt balo	2021-04	SD348	ORBERA Intragastric Balloon System (balloon, placement catheter a	item	$ 1,850	1	$ 1,850	1	$ 1,850	68.82	$ 2,226
36560	Insert tunneled cv cath	2003-04	SA011	kit, CVA catheter, tunneled, with subcut port	kit	$ 511	1	$ 511	1	$ 511	27.78	$ 899
37243	Vasc embolize/occlude organ	2013-04	SF058	LC Beads (2mL vial)	item	$ 2,342	3	$ 7,026	3,492	$ 24,534,059	229.43	$ 7,421
69706	Nps surg dilat eust tube bi	2020-01	SA134	kit, eustachian tube procedure	kit	$ 2,010	1	$ 2,010	2,217	$ 4,456,170	74.42	$ 2,407
36570	Insert picvad cath	2003-04	SA025	kit, PICC with subcut port	kit	$ 718	1	$ 718	1	$ 718	34.99	$ 1,132
22510	Perq cervicothoracic inject	2014-04	SA039	kit, vertebroplasty (LP2, CDO)	kit	$ 970	1	$ 970	43	$ 41,731	42.85	$ 1,386
37188	Ven mechnl thrmbc repeat tx	2005-04	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$ 696	1	$ 696	3	$ 2,089	34.69	$ 1,122
22511	Perq lumbosacral injection	2014-04	SA039	kit, vertebroplasty (LP2, CDO)	kit	$ 970	1	$ 970	183	$ 177,598	43.46	$ 1,406
20697	App mltpln uni xtrnl fix xch	2008-04	SD240	strut, replacement, dynamic external fixation	item	$ 1,186	1	$ 1,186	23	$ 27,273	50.73	$ 1,641
47383	Perq abltj lvr cryoablation	2014-04	SD233	probe, cryoablation, renal	item	$ 1,170	4	$ 4,681	51	$ 238,725	159.2	$ 5,150
36903	Intro cath dialysis circuit	2016-01	SD254	covered stent (VIABAHN, Gore)	item	$ 3,129	1	$ 3,129	4,971	$ 15,554,259	111.45	$ 3,605
45346	Sigmoidoscopy w/ablation	2013-10	SC103	catheter, RF ablation, endoscopic	item	$ 1,500	1	$ 1,500	52	$ 78,000	61.24	$ 1,981
37191	Ins endovas vena cava filtr	2011-04	SD267	IVC filter	item	$ 1,195	1	$ 1,195	475	$ 567,744	51.91	$ 1,679
47538	Perq plmt bile duct stent	2015-10	SD313	Viabil covered biliary stent	Item	$ 2,766	1	$ 2,766	7	$ 19,360	100.66	$ 3,256
37183	Revision tips	2002-02	SD238	stent, GORE VIATORR TIPS Endoprosthesis	item	$ 4,523	1	$ 4,523	6	$ 27,138	155.15	$ 5,019
44401	Colonoscopy with ablation	2014-01	SC103	catheter, RF ablation, endoscopic	item	$ 1,500	1	$ 1,500	1	$ 1,500	61.83	$ 2,000
45388	Colonoscopy w/ablation	2014-01	SC103	catheter, RF ablation, endoscopic	item	$ 1,500	1	$ 1,500	1,132	$ 1,698,000	63.54	$ 2,055
37184	Prim art m-thrmbc 1st vsl	2005-04	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$ 696	1	$ 696	1,186	$ 825,895	38.82	$ 1,256
37187	Venous mech thrombectomy	2005-04	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$ 696	1	$ 696	682	$ 474,924	38.84	$ 1,256
36516	Apheresis immunoads slctv	2017-01	SD186	plasma LDL adsorption column (Liposorber)	item	$ 1,419	1	$ 1,419	572	$ 811,691	62.15	$ 2,010
19105	Cryosurg ablate fa each	2006-04	SD232	probe, cryoablation (Visica ICE 30 or 40)	item	$ 1,372	1	$ 1,372	5	$ 6,861	60.78	$ 1,966
32994	Ablate pulm tumor perq crybl	2017-01	SD233	probe, cryoablation, renal	item	$ 1,170	3	$ 3,511	5	$ 17,553	127.79	$ 4,134
65785	Impltj ntrstrml crnl rng seg	2015-01	SA120	intrastromal corneal ring	pair	$ 1,145	1	$ 1,145	19	$ 21,755	54.97	$ 1,778
20982	Ablate bone tumor(s) perq	2003-09	SD109	probe, radiofrequency, 3 array (StarBurstSDE)	item	$ 2,289	1	$ 2,289	105	$ 240,345	91.66	$ 2,965
36904	Thrmbc/nfs dialysis circuit	2016-01	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$ 696	1	$ 696	367	$ 255,568	42.93	$ 1,389
37244	Vasc embolize/occlude bleed	2013-04	SF056	Detachable coil	item	$ 1,199	4	$ 4,797	362	$ 1,736,586	170.05	$ 5,501
47539	Perq plmt bile duct stent	2015-10	SD313	Viabil covered biliary stent	Item	$ 2,766	1	$ 2,766	1	$ 2,766	108.62	$ 3,513
55873	Cryoablate prostate	2009-02	SA099	Kit, probe, cryoablation, prostate (Galil-Endocare)	kit	$ 4,000	1	$ 4,000	58	$ 232,000	147.79	$ 4,780
47540	Perq plmt bile duct stent	2015-10	SD313	Viabil covered biliary stent	Item	$ 2,766	1	$ 2,766	1	$ 2,766	109.72	$ 3,549
64555	Implant neuroelectrodes	2017-01	SD280	Trial lead kit	item	$ 959	1	$ 959	1,163	$ 1,115,247	55.07	$ 1,781
47382	Percut ablate liver rf	2002-02	SA100	kit, probe, radiofrequency, Xli-enhanced RF probe	kit	$ 1,967	1	$ 1,967	29	$ 57,033	87.64	$ 2,835
63650	Implant neuroelectrodes	2008-02	SD280	Trial lead kit	item	$ 959	1	$ 959	16,151	$ 15,487,533	57.79	$ 1,869
20983	Ablate bone tumor(s) perq	2014-04	SD233	probe, cryoablation, renal	item	$ 1,170	3	$ 3,511	12	$ 42,128	137.69	$ 4,454
36905	Thrmbc/nfs dialysis circuit	2016-01	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$ 696	1	$ 696	6,635	$ 4,620,415	54.27	$ 1,755
64555	Implant neuroelectrodes	2017-01	SD281	Trial lead array	item	$ 641	1	$ 641	1,163	$ 745,332	55.07	$ 1,781
22513	Perq vertebral augmentation	2014-04	SA111	Kyphoplasty kit, first fracture	kit	$ 3,721	1	$ 3,721	5,713	$ 21,256,930	150.73	$ 4,876
22514	Perq vertebral augmentation	2014-04	SA111	Kyphoplasty kit, first fracture	kit	$ 3,721	1	$ 3,721	6,691	$ 24,895,873	150.75	$ 4,876
63650	Implant neuroelectrodes	2008-02	SD281	Trial lead array	item	$ 641	1	$ 641	16,151	$ 10,350,486	57.79	$ 1,869
21125	Augmentation mndblr prostc	1995-08	SD191	plate, surgical, reconstruction, left, 5 x 16 hole	item	$ 846	1	$ 846	1	$ 846	64.35	$ 2,081
37236	Open/perq place stent 1st	2013-04	SD299	stent, balloon, implantable	item	$ 812	1	$ 812	1,058	$ 859,551	66.79	$ 2,160

36906	Thrmbc/nfs dialysis circuit	2016-01	SD254	covered stent (VIABAHN, Gore)	item	$	3,129	1	$	3,129	2,815	$	8,808,135	139.71	$	4,519
36837	Prq av fstl crt uxtr sep acs	2022-01	SD350	Wavelinq EndoAVF catheters	item	$	7,000	1	$	7,000	96	$	672,000	260.34	$	8,421
37221	Iliac revasc w/stent	2010-04	SA103	stent, vascular, deployment system, Cordis SMART	kit	$	804	1	$	804	4,443	$	3,570,306	74.63	$	2,414
37228	Tib/per revasc w/tla	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	5,806	$	6,635,619	102.86	$	3,327
64553	Implant neuroelectrodes	2017-01	SD280	Trial lead kit	item	$	959	1	$	959	2	$	1,918	103.09	$	3,335
21127	Augmentation mndblr b1 grf	2003-08 PE Review	SD191	plate, surgical, reconstruction, left, 5 x 16 hole	item	$	846	1	$	846	706	$	597,594	103.65	$	3,353
21215	Lower jaw bone graft	2003-08 PE Review	SD191	plate, surgical, reconstruction, left, 5 x 16 hole	item	$	846	1	$	846	4,235	$	3,584,716	106.38	$	3,441
37241	Vasc embolize/occlude venous	2013-04	SF056	Detachable coil	item	$	1,199	1	$	1,199	235	$	281,836	119.77	$	3,874
64553	Implant neuroelectrodes	2017-01	SD281	Trial lead array	item	$	641	1	$	641	2	$	1,282	103.09	$	3,335
37226	Fem/popl revasc w/stent	2010-04	SD254	covered stent (VIABAHN, Gore)	item	$	3,129	1	$	3,129	1,911	$	5,979,519	213.49	$	6,906
36906	Thrmbc/nfs dialysis circuit	2016-01	SA015	kit, for percutaneous thrombolytic device (Trerotola)	kit	$	696	1	$	696	2,815	$	1,960,282	139.71	$	4,519
37230	Tib/per revasc w/stent	2010-04	SD266	stent, self expanding 2-5 mm XPERT (Abbott)	item	$	3,308	1	$	3,308	323	$	1,068,384	233.13	$	7,541
37225	Fem/popl revas w/ather	2010-04	SD253	atherectomy device (Spectronetics laser or Fox Hollow)	kit	$	3,048	1	$	3,048	27,176	$	82,841,416	230.03	$	7,441
37229	Tib/per revasc w/ather	2010-04	SD253	atherectomy device (Spectronetics laser or Fox Hollow)	kit	$	3,048	1	$	3,048	30,722	$	93,650,794	232.95	$	7,535
37226	Fem/popl revasc w/stent	2010-04	SD255	Reentry device (Frontier, Outback, Pioneer)	item	$	2,343	1	$	2,343	1,911	$	4,477,702	213.49	$	6,906
37225	Fem/popl revas w/ather	2010-04	SD255	Reentry device (Frontier, Outback, Pioneer)	item	$	2,343	1	$	2,343	27,176	$	63,676,629	230.03	$	7,441
37229	Tib/per revasc w/ather	2010-04	SD255	Reentry device (Frontier, Outback, Pioneer)	item	$	2,343	1	$	2,343	30,722	$	71,985,333	232.95	$	7,535
37230	Tib/per revasc w/stent	2010-04	SD255	Reentry device (Frontier, Outback, Pioneer)	item	$	2,343	1	$	2,343	323	$	756,828	233.13	$	7,541
37226	Fem/popl revasc w/stent	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	1,911	$	2,184,063	213.49	$	6,906
37225	Fem/popl revas w/ather	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	27,176	$	31,059,179	230.03	$	7,441
37229	Tib/per revasc w/ather	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	30,722	$	35,111,867	232.95	$	7,535
37230	Tib/per revasc w/stent	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	323	$	369,153	233.13	$	7,541
37227	Fem/popl revasc stnt & ather	2010-04	SD254	covered stent (VIABAHN, Gore)	item	$	3,129	1	$	3,129	13,641	$	42,682,689	294.67	$	9,532
37227	Fem/popl revasc stnt & ather	2010-04	SD253	atherectomy device (Spectronetics laser or Fox Hollow)	kit	$	3,048	1	$	3,048	13,641	$	41,582,270	294.67	$	9,532
37231	Tib/per revasc stent & ather	2010-04	SD266	stent, self expanding 2-5 mm XPERT (Abbott)	item	$	3,308	1	$	3,308	2,225	$	7,359,610	310.05	$	10,029
37231	Tib/per revasc stent & ather	2010-04	SD253	atherectomy device (Spectronetics laser or Fox Hollow)	kit	$	3,048	1	$	3,048	2,225	$	6,782,534	310.05	$	10,029
37227	Fem/popl revasc stnt & ather	2010-04	SD255	Reentry device (Frontier, Outback, Pioneer)	item	$	2,343	1	$	2,343	13,641	$	31,962,500	294.67	$	9,532
36837	Prq av fstl crt uxtr sep acs	2022-01	SF056	Detachable coil	item	$	1,199	1	$	1,199	96	$	115,133	260.34	$	8,421
37231	Tib/per revasc stent & ather	2010-04	SD255	Reentry device (Frontier, Outback, Pioneer)	item	$	2,343	1	$	2,343	2,225	$	5,213,442	310.05	$	10,029
37227	Fem/popl revasc stnt & ather	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	13,641	$	15,590,162	294.67	$	9,532
37231	Tib/per revasc stent & ather	2010-04	SD256	Embolic Protection Device Spider FX (EV3, documentation available	item	$	1,143	1	$	1,143	2,225	$	2,542,930	310.05	$	10,029

AMA/Specialty Society RVS Update Committee **Tab 26**
Multi-Specialty Points of Comparison (MPC) Workgroup
January 16, 2025

Members: Amr Abouleish, MD (Chair), Jennifer Aloff, MD, Anita Arnold, DO, Charles Fitzpatrick, OD, Alexandra Flamm, MD, Gregory Harris, MD John Heiner, MD, Gwenn Jackson, MD, Kristopher Kimmell, MD, Howard P. Levy, MD, PhD, Bradley Marple, MD, Lauren Nicola, MD, John Proctor, MD

Review of the Service to Sunset off MPC List and Specialty Code Recommendations

The MPC Workgroup members reviewed proposals from several specialty societies for codes to be added, removed, or retained on the MPC list. Participating specialty societies used the MPC submission form to provide a more granular rationale for each code submission. Representatives from specialty societies attended the meeting to provide clarity and answer questions from MPC Workgroup members. The MPC Workgroup members noted that the specialty societies should be encouraged to take full advantage of the MPC review process to add new services and remove services that are no longer appropriate for the list. The MPC Workgroup reminded the specialty societies that any specialty with 10% or more Medicare utilization for a code should comment on the appropriateness of the addition or deletion of that code.

The MPC Workgroup members agreed to maintain 6 codes and delete 19 codes based on the sunset review, delete another 8 codes, and add 6 codes to the MPC list with justification provided by specialty societies in their recommendations.

I. Review of Services to Sunset – Recommendation to Maintain Codes on MPC List

In June 2021, the MPC Workgroup recommended identifying and reviewing codes on the MPC list that have not been reviewed in the last 15 years as part of its annual review. This year, there were 25 services on the MPC list that have not been RUC reviewed in the last 15 years. These codes have been reviewed by the specialties, and they have submitted their recommendations to either "maintain" or "delete" these services, along with their supporting rationale.

The American College of Emergency Physicians recommended maintaining 93042 on the MPC list, to which the MPC Workgroup agreed. The American Society of Anesthesiologists recommended maintaining 62350, 63661, 64480 and 64484 on the MPC list, to which the MPC Workgroup agreed. The American Society of Plastic Surgeons (ASPS) and the American Academy of Dermatology originally submitted a recommendation to maintain 15576 on the MPC list. Prior to the meeting, the two specialty societies decided to change their recommendation and instead recommended it sunset off the MPC list. The Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and ASPS recommended maintaining 21556, to which the MPC Workgroup agreed. AAO-HNS and ASPS also recommended maintaining 25071 on the MPC list but decided to withdraw their recommendation and let the code sunset off the MPC list at the table. ASPS also recommended maintaining 26113 and 26116 on the MPC list but decided to withdraw their recommendation and let the codes sunset off the MPC list at the table.

The remaining 15 services set to sunset off the MPC list did not receive any specialty society response to maintain, thus the Workgroup agreed to delete them from the MPC list.

The MPC Workgroups recommends maintaining the following 6 services:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2024 Frequency
93042	Rhythm ECG, 1-3 leads; interpretation and report only	0.15	XXX	2009-10	254,371
64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	1.00	ZZZ	2009-10	312,293
64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	1.20	ZZZ	2009-10	12,417
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	5.08	010	2009-04	3,917
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	6.05	010	2008-02	3,564
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	7.66	090	2009-02	1,806

The MPC Workgroups recommends deleting the following 19 services:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2024 Frequency
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	0.05	XXX	2009-10	424,170
90935	Hemodialysis procedure with single evaluation by a physician or other qualified health care professional	1.48	000	2009-10	591,622
90945	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional	1.56	000	2009-10	110,046

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2024 Frequency
46930	Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	1.61	090	2008-04	4,900
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	1.75	XXX	2009-04	6
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	000	2009-10	859,451
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	2.11	000	2009-10	26,555
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	2.29	000	2009-10	35,847
51102	Aspiration of bladder; with insertion of suprapubic catheter	2.70	000	2008-04	13,204
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	5.91	090	2009-02	1,388
64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	6.36	090	2008-04	11,333
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	6.74	090	2009-02	3,773
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	7.13	090	2009-02	1,532
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	7.56	090	2008-04	913
54530	Orchiectomy, radical, for tumor; inguinal approach	8.46	090	2008-02	957
15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral	9.37	090	2008-10	4,359
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	10.03	090	2008-02	2,506
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	13.00	090	2008-02	2,023
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	15.18	090	2008-02	1,159

II. MPC List Services Deletions

The MPC Workgroup annually solicits the specialty societies for codes that should be added to or deleted from the MPC list. There were 8 services recommended for deletion from the MPC list by the American Urological Association. The MPC Workgroup clarified that 7 of those codes including 55700, 38571, 52601, 52649, 55840, 55866 and 55845 should have been previously removed due to the fact that these services were under review at the September 2024 RUC meeting and thus is appropriate they be deleted. The MPC agreed that those 7 codes, as well as 53850, should be deleted from the MPC list.

The MPC Workgroup recommends deleting the following 8 services from the MPC list:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2024 Frequency
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2.50	000	2016-01	138,394
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	5.42	090	2018-01	745
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	12.00	010	2014-09	16,367
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	13.16	090	2016-04	38,400
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	14.56	090	2010-10	8,670
55840	Prostatectomy, retropubic radical, with or without nerve sparing;	21.36	090	2014-04	1,014
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	22.46	090	2022-01	18,044
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	25.18	090	2014-04	398

III. MPC List Services Additions

The MPC Workgroup annually solicits the specialty societies for codes that should be added to or deleted from the MPC list. There were 6 services recommended for addition to the MPC list by the American Academy of Audiology and the American Speech-Language-Hearing Association. The MPC Workgroup agreed with the addition of these services.

The MPC Workgroup recommends adding the following 6 services to the MPC List:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2024 Frequency
92542	Positional nystagmus test, minimum of 4 positions, with recording	0.48	XXX	2014-04	15,514
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	0.80	XXX	2019-04	7,501
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	1.05	XXX	2019-04	7,857
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	1.20	XXX	2019-04	4,819
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	1.40	XXX	2018-10	20,187
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	1.50	XXX	2019-04	4,677

IV. Other Business

The MPC Workgroup discussed several additions and clarifications to the MPC History, Process and Criteria document. This included the addition of language in the list of the MPC Workgroup's responsibilities to more clearly articulate MPC protocol and screens as such (see bold underlined text):

The MPC workgroup shall maintain the responsibility of updating the MPC, using the established process, including:

- Annually review the process of MPC maintenance, identify gaps in the MPC codes related to RVUs and global period assignment.
- **AMA staff will remove codes from the MPC when they are identified to be surveyed at a RUC meeting. Specialties may renominate a code to be added to the MPC list when the code valuation is published in the CMS Final Rule.**

- Review the codes on the current MPC list that have been valued more than 15 years prior and identify those to be retained according to the new criteria. **Once a code has been identified and reviewed, it will be reviewed every other year after for as long as it is on the MPC list.**

- Review MPC list for deficiencies or problems, then craft strategies to resolve.

- The MPC list will require continuous review and refinement with codes added and deleted from specialty society nominations and MPC Workgroup review.

Additionally, the Workgroup discussed revising the language in the Absolute Criteria section of the MPC History, Process and Criteria document and striking the word "should" from all three criteria. In their discussion, the Workgroup agreed that this revision would better distinguish Absolute Criteria from the Suggested Criteria section and provide a more rigorous standard for what it means for a code to meet the Absolute Criteria. The following revisions are listed below (see bold underlined text):

Absolute Criteria:

- The codes **~~should~~** have current work RVUs that the specialty(s), RUC, and CMS accept as valid.
- Any specialty(s) that perform(s) greater than 10% of the total utilization or greater than 10,000 billing instances of the service **~~should have~~** has the right to consider the appropriateness of the inclusion of the service on the MPC list. The MPC Workgroup will review that request in consultation with the performing specialty(s), which shall be offered the opportunity to comment, and make a recommendation to the RUC for final determination.
- Any code included in the MPC list **~~should have~~** has gone through the RUC survey process and have RUC approved time.

The Workgroup agreed that these revisions be made during the January 2025 RUC meeting so that the MPC History, Process and Criteria document is prepared for the April 2025 RUC meeting.

AMA/Specialty Society RVS Update Committee **Tab 27**
Relativity Assessment Workgroup
January 16, 2025

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

I. Review Action Plans

High Volume Growth

Chemical Cauterization of Granulation Tissue (17250)
In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. In January 2016, the Relativity Assessment Workgroup recommended referring this code to CPT to revise the descriptor or include a parenthetical regarding appropriately reporting 17250 or 97597 and 97598. It was referred to CPT Assistant to describe when to appropriately report 17250 or 97597 and 97598. The Workgroup noted it would review utilization data and who is providing this service in October 2019. In September 2016, the CPT Editorial Panel editorially revised this code and additional guidelines for reporting chemical cauterization. In October 2019, the Workgroup recommended reviewing again in two years (January 2022). In January 2022, the Workgroup reviewed CPT code 17250 and noted that the dominant Medicare provider is Family Medicine in the nursing facility and skilled nursing facility. The specialty societies indicated that the increase in CPT code 17250 reporting was due to this service's absence from the consolidated billing list of codes for nursing facilities. The specialty societies indicated that the American Academy of Family Physicians (AAFP) would publish a membership educational article and that this service be re-reviewed. The Workgroup recommended that CPT code 17250 be re-reviewed in 3 years (January 2025) following publication of an AAFP membership educational article and additional utilization data is obtained. The Workgroup recommended that the RUC notify CMS that CPT code 17250 should be added to the consolidated billing list of codes for nursing facilities to curb the misreporting for work that is paid to the facility. AAFP published a coding educational article in May 2022 in the FPM Journal. The specialty societies submitted an action plan for January 2025 to assess the growth for this service.

In January 2022, the specialty societies recommended to monitor the Medicare utilization and review again in three years (January 2025) and recommend CMS add 17250 to consolidated billing for nursing facility services (which the RUC did recommend in the January 2022 submission of recommendations to CMS). **The Workgroup agreed with the specialty societies and recommends to review CPT code 17250 in two years (January 2027) and reiterate the request that CMS add 17250 to consolidated billing for nursing facility services.** The Workgroup also noted that there appears to be a different population of physicians currently performing this service compared to who originally surveyed and that this may be identified on the next reiteration of that screen.

Stereotactic Computer-Assisted Volumetric Navigational Procedures (61783)
In April 2024, the Relativity Assessment Workgroup identified these services via the high volume growth screen, with Medicare utilization over 10,000 that has increased by at least 100% from 2017 through 2022. The specialty societies were requested to submit an action plan for review at the September 2024 RAW meeting. This item was deferred to the January 2025 RAW meeting to allow presenters to be available to speak about this issue.

In January 2025, the Workgroup reviewed the action plan for CPT code 61783 and determined that this service was last valued in 2010 and utilization is steadily increasing, thus should be surveyed with the appropriate family of codes for April 2025.

Referral from CPT – Thyroidectomy (60240, 60260)

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

> Tab I: Other Business - Issue 2: Tab 28 - Thyroidectomy 60260 Parenthetical Deletion
> The Panel Chair provided an overview of the issue, which was derived from a previous CPT Assistant Editorial Board recommendation regarding proper coding for CPT code 60260. Specifically, the Editorial Board was seeking clarity on whether the code referred to removal of a lobe of the thyroid, or to removal of all remaining thyroid tissue.
>
> The AAO-HNS attempted to address this issue via a CCA (Tab 28) submitted for the October 2021 meeting. However, based on additional feedback from the ACS Advisors and Panel reviewers, it was withdrawn prior to the meeting. Given the withdraw, the EC, during their deliberations, discussed potential next steps.
> The Panel discussed precedent for sending something back to the RUC. The EC members noted that while this may be rare, it provided an opportunity for the RUC to potentially address an issue that goes beyond just code structure. Furthermore, having the issue tracked as part of a RUC screen/issue may ensure the issue gets addressed through additional mechanisms for tracking and feedback.
>
> The Panel approved the EC recommendation to refer this issue to the RUC to further consider whether CPT codes 60240 and 60260 represent a rank order anomaly.

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

CPT Code	Descriptor	work RVU	Pre-Time	Intra-Time	Immed Post	Post-Op	Total Time
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11.19	40/12/20	90	40	99238=0.5 99213=2	267
60240	Thyroidectomy, total or complete	15.04	40/12/20	150	40	99238=0.5 99213=2	327
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	18.26	60	145	30	99231=1 99232=1 99238=1 99212=1 99213=1	372

In January 2025, the Workgroup discussed the possible work order anomaly with 60240 and 60260. The specialties explained that there is not a rank order anomaly between 60240 and 60260. The pre/intra/post service times are relatively the same, but the post-operative visits are quite different. CPT code 60260 requires post-operative hospital visits, whereas CPT 60240 does not, which is primary reason for the difference in work RVU. The post-operative hospital visits in CPT code 60260 (1-99231 and 1-99232) are necessary to monitor the patient's calcium levels every few hours. Patient's who have had a previous

operation on the neck must be monitored to ensure that the parathyroid glands were not disrupted, in turn disrupting the patient's regulation of calcium levels. Therefore, the patient must stay in the hospital longer to ensure they are stable. **The Workgroup agreed with the specialty societies that there is not a rank order anomaly between 60240 and 60260 and will notify the CPT Editorial Panel/CPT Assistant Board and agreed that this issue be referred to CPT Assistant to develop an article that revises the 2010 CPTA Q&A guidance and includes numerous clinical examples to support education about correct coding for thyroidectomy procedures.**

CMS High Expenditure Screen – Angiography of Extremities (75710)

In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In October 2016, the RUC noted that with the newly bundled dialysis access maintenance codes that were approved in January 2016 as part of Dialysis Circuit code family 36901-36909, the specialties project that a significant portion of the nephrology volume for 75710 will instead be reported with applicable Dialysis Circuit codes. Nephrology represented 17.8 percent of the 2015 Medicare claims for 75710. The RUC will add a flag for review to confirm that nephrology utilization volume has decreased once 2017 Medicare utilization data is available for review. The RUC noted the nephrology utilization is slightly decreasing. The RUC recommended reviewing utilization again in 2 years (Oct 2020). In October 2020, the Workgroup reviewed the history of this code and the action plan submitted by SVS, SIR, ACR and ACC. Noting that the 2019e utilization by nephrologists was gradually decreasing (13%) (global & -26 modifier). The Workgroup questioned if the gradual decrease in utilization by nephrologists is appropriate or if nephrologists should not be performing this service at all. The Workgroup noted that RPA was not involved in the development of this action plan. The Workgroup requested the input from Nephrology regarding the reporting of CPT code 75710 and review at the January 2021 meeting. In January 2021, the Relativity Assessment Workgroup noted that the utilization of nephrology continues to decrease but not at the rate the specialty societies thought it would. The specialty societies indicated that they would submit a CPT Assistant article to address the appropriate reporting of this service. The Workgroup recommended that this service be referred to CPT Assistant and reviewed after 2 years of data are available after the publication of the article. The specialty societies noted that the expected utilization for Nephrology would be under 10%. CPT Assistant coding brief was published in July 2021.

2015 Medicare Utilization		**2016 Medicare Utilization**		**2017 Medicare Utilization**		**2018 Medicare Utilization**	
Vascular Surgery	30%	Vascular Surgery	31%	Vascular Surgery	34%	Vascular Surgery	34%
Nephrology	**18%**	**Nephrology**	**18%**	**Nephrology**	**15%**	**Nephrology**	**14%**
Cardiology	18%	Cardiology	15%	Cardiology	14%	Cardiology	13%

2019 Medicare Utilization		**2020 Medicare Utilization**		**2021 Medicare Utilization**		**2022 Medicare Utilization**	
Vascular Surgery	35%	Vascular Surgery	36%	Vascular Surgery	38%	Vascular Surgery	40%
Nephrology	**13%**	**Nephrology**	**14%**	IR	12%	IR	13%
Cardiology	12%	IR	11%	**Nephrology**	**11%**	Cardiology	11%
						Nephrology	**10%**

2023 Medicare Utilization	
Vascular Surgery	41%
Interventional Radiology	13%
Cardiology	11%
Nephrology	**9.5%**

In January 2025, the Workgroup noted that CPT code 75710 is provided by Nephrology 9% of the time based on the 2023 Medicare data. The specialties confirmed that the typical utilization by Nephrology should be 8-10%, thus this falls appropriately in the range expected and will probably remain around that percentage. **The Workgroup determined the physicians performing CPT code 75710 based on the Medicare data is appropriate and CPT 75710 be maintained and removed from this screen.**

Work Neutrality CPT 2018 – Home INR Monitoring (93792, 93793)

In January 2016, the RAW recommended to survey G0250 along with G0248 and G0249 for April 2016. In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and these services were identified. In April 2016, the specialty society indicated that they intend to develop Category I codes to describe home INR monitoring services for the September 2016 CPT meeting with review at the January 2017 RUC meeting. The RUC recommends that codes G0248, G0249 and G0250 be referred to CPT to create Category I codes to describe these services. In September 2016, the Editorial Panel deleted 99363 and 99364 and created two new codes. In October 2019, the RUC identified this family as having more than a 10% increase (311%) in work RVUs for 2018 than what was projected. In January 2020, the Workgroup noted CMS created G0250 to describe these services before 93792 and 93793 were developed. The Workgroup noted that 93792 and 93793 were new codes and an increase was expected as these services were not specifically described before. The Workgroup also noted that the RUC recommended that CMS delete G0250 at that time. CMS did not delete these G codes as they describe different tests. The Workgroup recommended reviewing in 2 years and continued to support the specialty societies' recommendation that CMS delete the G code. In January 2022, the Workgroup reviewed this family of services. The specialty societies indicated that these services were never projected as work neutral. CMS created the G codes to report home INR testing and interpretation when it issued a national coverage determination (NCD) covering home INR services. G0248 is the initial training of home INR with some supplies and equipment and staff time. G0249 is resupply for another month of home INR. G0250 is interpretation/management of one month of home INR, or four tests. When these G codes appeared on the RUC high volume growth screen, the societies approached CPT to create CPT codes that capture those three elements, but also capture the broader work of anticoagulation management for any INR test wherever it is obtained. G0248 is basically equal to 93792. CPT did not want to create an equivalent PE-only re-supply code equivalent to G0249. In the new code construct, G0250 would be the same as four individual 93793s. In addition, 93793 could be billed if a patient went to a lab to get an INR test or had one done in the clinician's office, although it is not reportable the same day as an E/M. A revised neutrality calculation in the spreadsheet demonstrates that if source utilization of G0250 is multiplied by 4, as was the original intent of the societies, budget neutrality was within 3% in 2018. The specialty societies continue to request that CMS delete G0248, G0249 and G0250, however, note that these services will soon become obsolete. Fewer patients have the associated mechanical valves and warfarin use will diminish as a management option. The Workgroup recommended that CMS delete G0248, G0249 and G0250 and CPT codes 93792 and 93793 be maintained and reviewed by the Relativity Assessment Workgroup in 3 years (January 2025).

In January 2025, the Workgroup reviewed the action plan for CPT codes 93792 and 93793 and agreed with the specialty societies to remove from work neutrality screen. Incorrect assumptions were made initially and these services were budget neutral. Additionally, Medicare utilization continues to decrease. The Workgroup recommended that CMS delete G0248, G0249 and G0250 and CPT codes 93792 and 93793 be maintained.

II. Do Not Use to Validate Physician Work Flag Screen

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

In September 2024, the five groupings of rationale for the "do not use" flag were identified.

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

The Workgroup noted that providing a more granular description of the "do not use" flags in the RUC database would be helpful. The Workgroup requested that AMA staff work with the Workgroup Chair determine if additional data or screens may be developed based on some parameters for low survey response flagged codes.

"Other" Specific Flag Noted Codes

There are 73 other specific reasons codes were flagged as "do not use", of which 28 codes were flagged due to a low survey response rate. In 2018, the RUC adopted a policy on how to address and monitor codes the RUC reviews that had a survey response rate below the minimum of 30.

> **Proposed at the January 11, 2018, Administrative Subcommittee meeting and approved at the January 10-13, 2018, RUC meeting:**
>
> ***Low Survey Responses/Contractor Pricing***
> **The Administrative Subcommittee reviewed the history of low survey responses and determined that the RUC should not automatically recommend contractor pricing codes that have a low response rate (under 30), but continue its current process and review each unique code set individually.** The Subcommittee indicated that its main concern is that new Category I CPT codes are created when in reality the services are not widely performed and a valid survey with 30 responses is not obtainable. **The Administrative Subcommittee recommends that the RUC flag new Category I services with a survey response below 30 to be reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.**

Therefore, of the 28 codes flagged for a low response rate, 21 are already scheduled to be reviewed by the RAW. There are 7 codes that were flagged prior to the RUC policy and have not been addressed and need to be examined further. Two services, codes 43284 and 43285, were reviewed on the new technology/new services list in April 2024 and were removed from further review on that list**. The Workgroup discussed and recommended that the DNU flag of low survey response codes 43284 and 43285 should remain on flagged on the DNU list and an action plan be submitted in April 2025.** The Workgroup noted that the flag for 31605 and 31610 is "do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU."

Therefore, the Workgroup determined that the flag for 31605 and 31610 be changed to "atypical valuation methodology" however, an action plan should be submitted in April 2025. The Workgroup requested that specialty societies submit an action plan for the three other codes (67255, 67505, and 64400) in April 2025 to address if the DNU flag should remain for these low response rate surveyed codes.

The Workgroup reviewed the remaining 43 "other specific" DNU flagged codes to determine if 1) these codes should remain flagged in the RUC database and 2) if the service should remain flagged, what specific code grouping should be noted in the RUC database. **The Workgroup determined that all 43 other specific DNU flagged codes should remain flagged in the RUC database and that the three categories "valued by building block", "valued by crosswalk" and "valued by increment" be streamlined to be flagged as "atypical value methodology" instead.**

The Workgroup recommends the following 12 titles for "other specific flags":

1. **Add-On Valued as separately reported**
2. **Anomalous intra-service time**
3. **Co-surgeon service**
4. **Low survey performance rate**
5. **Low survey response**
6. **Low volume code**
7. **Negative IWPUT**
8. **Not surveyed**
9. **Service times not representative**
10. **Survey demonstrated increase, however, no compelling evidence**
11. **Atypical valuation methodology**
12. **Vignette issue**

The detailed flag descriptions for these 73 services are in the attached DNU Codes spreadsheet and should be noted in the RUC database as such.

The Workgroup discussed the low survey response flagged codes and changed CPT code 64400 to be flagged as "atypical value methodology" instead. The Workgroup determined that the remaining 25 low survey response flagged codes will continue to be reviewed under the scheduled timeline and process already established.

The Workgroup discussed that it should establish a process to review all other specific flagged codes after a number of years after they are flagged. **The Workgroup determined that it should reexamine the 48 other specific flagged codes that are currently flagged in detail by reviewing an action plan from the specialty societies. The Workgroup will spread this review over the next three RAW meetings, first looking at the top 1/3 or 16 codes with the highest Medicare utilization. The Workgroup will review action plans to determine if the top 16 DNU specific flagged codes should be resurveyed, revised at CPT, maintained with the flag or the flag removed. The goal will be to find a way to resolve the issue that led to the flag, if possible.** The Workgroup noted if a code is on the new technology/new services list already scheduled for review, that those codes be maintained on that list and address the new technology/new service and DNU flag at the same time.

The Workgroup determined that codes flagged as DNU in the future and categorized within one of the "other specific flags" above be systematically reviewed by the Relativity Assessment Workgroup after three years of data are available to determine if the codes should be resurveyed, revised at CPT, maintained with the flag or the flag removed. The goal will be to find a way to resolve the issue that

led to the flag, if possible. The Workgroup noted if a code is on another screen already scheduled for review, that those codes be maintained on that list and address both that screen and the DNU flag at the same time.

The Workgroup reviewed the four other groupings for the remaining 311 DNU flagged codes and concluded the rationale was clear and these flags should remain without further review by the Workgroup.

1. **Reallocation of physician time components for PE purposes**
2. **Surveyed physician time has not been validated by the RUC**
3. **Molecular pathology codes, not covered on MFS**
4. **CMS increased independent of RUC review.**

The detailed flag descriptions for these 311 services are in the attached DNU Codes spreadsheet and should be noted in the RUC database as such.

III. Hyperbaric Oxygen Under Pressure

CPT code 99183 *Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session* was first identified in April 2013 via the CMS/Other - Utilization over 250,000 screen. It was surveyed and reviewed by the RUC in January 2014. The RUC subsequently submitted work and direct PE input recommendations based on a typical treatment time of 120 minutes. For CY 2015, CMS accepted the RUC's work recommendation though decided to assign 99183 no direct PE inputs. Instead, CMS opted to make 99183 a professional component only code and created a separate time-based G code to report the technical component for hyperbaric oxygen therapy (PE-only code G0277 *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval*). To value G0277, CMS used the RUC recommended direct PE inputs for 99183 and adjusted them to align with the 30-minute treatment interval. In the Final Rule for 2015, CMS commented that prior to 2015, CPT code 99183 was used for both professional attendance and supervision and the actual treatment delivery. Stakeholders had pointed out that although CMS included the PE inputs for treatment delivery in CPT code 99183 prior to 2015, the code descriptor described only attendance and supervision. CMS noted that under the Outpatient Prospective Payment System (OPPS), the treatment used to be reported using separate treatment code C1300 *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval*. Therefore, CMS created code G0277 to report the treatment delivery and to maintain consistency with the OPPS coding. CMS used a timed 30-minute code, which can be used across settings. When G0277 is reported in the facility setting, the HOPPS uses Ambulatory Payment Classifications (APC) code 5061 *Hyperbaric Oxygen Therapy*.

In April 2022, the Relativity Assessment Workgroup identified G0277 via the high volume growth screen, with Medicare utilization of 10,000 or more that increased by at least 100% from 2015 through 2020. In September 2022, the Workgroup reviewed an action plan from the specialty societies and the RUC recommended that the practice expense be reviewed at the January 2023 RUC Meeting. The RUC made recommendations on the direct practice expense inputs for G0277 and recommended that CPT code 99183 be referred to CPT by the June 2023 deadline for the September 2023 CPT meeting, for revision to be time-based as well as modified to appropriately describe the treatment delivery, attendance and supervision. Then, subsequently, allow for the deletion of G0277.

In September 2023, the specialties indicated they did not intend to submit a CCA. Therefore, this issue was placed on the January 2024 Relativity Assessment Workgroup agenda to address. In January 2024, the specialty societies indicated that they believe the current separate coding of the G code and the CPT code are clear and work appropriately. The Workgroup indicated that one clear and consistent coding

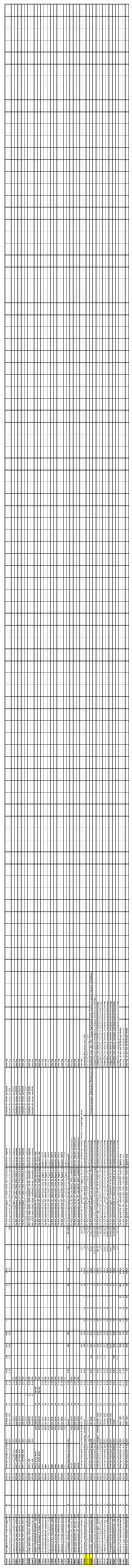
structure should exist and the specialty society should submit a CPT code change application. The specialties should revise 99183 to be time-based well as modified to appropriately describe the treatment delivery, attendance and supervision or develop a coding change creating a practice expense only code to capture the service appropriately and eliminate the need for G0277.

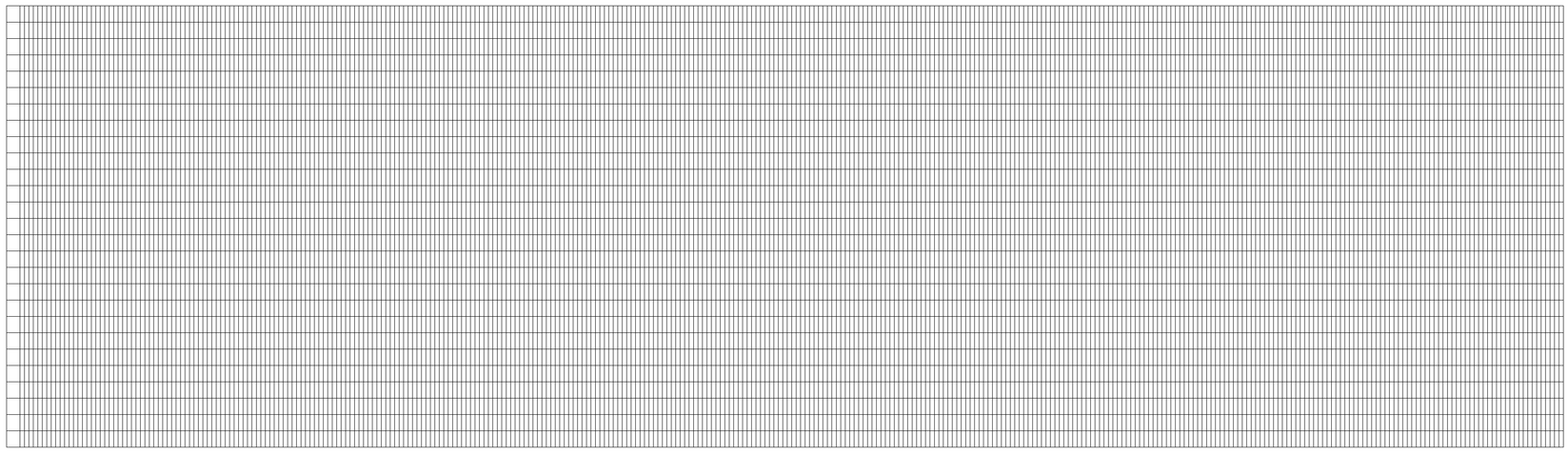
In September 2024, the specialty societies submitted a CCA to address the RUC's concerns. The specialty societies withdrew the application because it was apparent that the RUC referral to CPT was not going to provide a solution or align with CPT nomenclature/criteria. The CPT Editorial Panel does not split codes in the manner the RUC suggested. HCPCS code G0277 was not necessary as the sessions are uniform, with the 25th, median and 75th all indicating that 4 units or a two hour session is typical, which is what the RUC assumed for CPT code 99183.

The January 2023 RUC recommended inputs for G0277 are correct to crosswalk for CPT code 99183 if multiplied by 4, to account for four 30-minute units or 2 hours typical per session. **The Workgroup recommends that the RUC recommend that CMS crosswalk the recent January 2023 direct practice expense inputs for G0277, multiplying them by a factor of 4 for code 99183, and subsequently deleting G0277. This is consistent with affirming the RUC's original recommendation and assumption that this service is typically 120 minutes.**

VI. Informational Items

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





Members Present: Peter Hollmann, MD *(Chair),* Richard Rausch, DPT, MBA *(Co-Chair),* Leisha Eiten, AuD, CCA-A *(Alt. Co-Chair),* Amr Abouleish, MD, Kris Anderson, DC, MS, Shannon Butkus, PhD, CCC-SLP, Michael Doll, PA-C, Charles Fitzpatrick, OD, Harlivleen Gill, MBA, RDN, LDN, FAND, Jennifer Hodgson, PhD, LMFT, Scott Sperling, PsyD ABPP-CN, Nelda Spyres, LCSW, Korinne Van Keuren, DNP, MS, RN, Susan Walsh, DPM, MBA, Mary Walsh-Sterup, OTR/L, Robert Zwolak, MD

I. Introductions and CMS

Dr. Rausch welcomed the Health Care Professionals Advisory Committee (HCPAC) to the in-person meeting.

Ryan Howe, Director, Hospital and Ambulatory Policy Group (HAPG), Centers for Medicare & Medicaid Services (CMS), provided the HCPAC with an update and offered a reminder that the Proposed Rule will be released in July 2025. Mr. Howe expressed appreciation for non-MD/DO participation in the RUC HCPAC Review Board as CMS has institutional interest in hearing from the participating professional organizations as Rules are released and throughout the year.

II. HCPAC Review Board Co-Chair & Alternate Co-Chair Nominations & Election

The HCPAC Review Board conducted an election for the positions of Co-Chair and Alternate Co-Chair at their January 2025 meeting. The second term of the current Co-Chair, Richard Rausch, DPT, MBA, will conclude with the provision of the final recommendations to CMS on February 28, 2025 for CPT 2026 new, revised and potentially misvalued codes. Also, the second term of the Alternate Co-Chair, Leisha Eiten, AuD, CCA-A, will conclude February 28, 2025. The HCPAC Review Board and HCPAC Chair thanked Dr. Rausch for his service to the HCPAC over the last four years.

Leisha Eiten, AuD, CCA-A, was nominated for the position of HCPAC Review Board Co-Chair. Korinne Van Keuren, DNP, MS, RN and Mary Walsh-Sterup, OTR/L were nominated for the position of HCPAC Review Board Alternate Co-Chair. All parties were nominated by their respective specialty societies. **The HCPAC elected Leisha Eiten, AuD, CCA-A, Co-Chair and Korinne Van Keuren, DNP, MS, RN, Alternate Co-Chair. The new terms for both positions will begin March 1, 2025 and conclude in February 28, 2027.**

III. Relative Value Recommendations for CPT 2026

Remote Monitoring (PE Only)

In April 2022, the RUC identified code 99457 as a service that was surveyed by one specialty but is now performed by a different specialty. In September 2022, the Relativity Assessment Workgroup (RAW) reviewed an action plan on this service and recommended it be reviewed in two years (2021-2022 data) after utilization has stabilized after the pandemic. In April 2024, the RAW noted that 99457, along with the codes 99453, 99454 and 99458 were on the new technology/new services list for review. The specialty societies indicated that a coding application was submitted for May 2024 to review RPM/RTM codes (which may require survey of these codes) and to refer this issue to CPT Assistant regarding correct coding of this family of services. The RAW recommended that this code family be reviewed at the next RAW meeting in September 2024 to summarize what has occurred at the CPT Editorial Panel. The RAW noted that if this family was not addressed via the upcoming CPT process that the RAW should discuss when it would be surveyed. In September 2024, the RAW noted that a CCA for remote monitoring was reviewed at the September 2024 CPT meeting, which included codes 99453-99458. The RUC noted that 99453-99458 needed to be surveyed because the utilization of 99457 increased and the primary specialties who perform these services did not participate in the survey.

In September 2024, the CPT Editorial Panel added one code and made code revisions to report remote physiologic monitoring device supply for 2-15 days and 16-30 days within a 30-day period to report remote physiologic monitoring parameters; created one new code and code revisions to report remote physiologic monitoring treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; added three remote therapeutic monitoring device supply codes to report respiratory, musculoskeletal and cognitive behavioral therapy for 2-15 days and 16-30 days within a 30-day period; created one new code and made code revisions to report remote therapeutic monitoring treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; and revised the "Digitally Stored Data Services/Remote Physiologic Monitoring" guidelines, "Remote Physiologic Monitoring Treatment Management Services" guidelines, "Remote Therapeutic Monitoring Services" guidelines, and the "Remote Therapeutic Monitoring Treatment Management Services" guidelines. **The RUC HCPAC Review Board will submit practice expense recommendations for CPT codes 98986 and 98978.**

98986 ***Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period***

98978 ***Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period***

Codes 98986 and 98978 describe remote therapeutic monitoring for cognitive behavior therapy. The RUC HCPAC agreed with the specialty societies request for no clinical staff time and one new input for a digital therapeutic device. The RUC HCPAC recommend that a digital therapeutic device be added to the CMS direct PE medical supplies listing. The digital therapeutic device is an FDA-authorized product that helps healthcare providers conduct remote therapeutic monitoring to track clients' therapeutic progress and symptom status. These services and related digital therapeutic device are for monitoring only. It is a $50 monthly fee, per patient. This is supported by the invoices submitted. **The RUC HCPAC and Practice Expense Subcommittee recommend the input of a supply as submitted by the professional organization and will forward the invoices to CMS for pricing.**

New Technology
CPT codes 98986 and 98978 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

IV. Multi-Specialty Points of Comparison (MPC) List Updates

The HCPAC Review Board reviewed the addition of CPT codes 92517, 92519, 92568, 92652, and 92653 to the HCPAC Multi-Specialty Points of Comparison (MPC) list. **After review of the suggested criteria, the HCPAC voted to accept the addition of CPT codes 92517, 92519, 92568, 92652, and 92653 to the HCPAC MPC list given that it met the majority of absolute and suggested criteria (see table).**

CPT Code	CPT Descriptor	Global	Work RVU	Last Reviewed
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	XXX	0.80	2019-04
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	XXX	1.20	2019-04
92568	Acoustic reflex testing, threshold	XXX	0.29	2007-04
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	XXX	1.50	2019-04
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	XXX	1.05	2019-04

The HCPAC Review Board reviewed the proposed deletion of CPT code 92540 to the HCPAC Multi-Specialty Points of Comparison (MPC) list. After review of the proposal, the HCPAC voted to delete CPT code 92540 from the HCPAC MPC list given that the code was last reviewed in April 2009. Further, this code was replaced with code 92652 (see above) which is more recently reviewed and expands the spectrum of evoked response audiology services (see table).

CPT Code	CPT Descriptor	Global	Work RVU	Last Reviewed
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	XXX	1.50	2009-04

V. Other Business

A HCPAC Member requested that at the next review of the HCPAC Review Board MPC list in January 2026 HCPAC professional organizations are encouraged to review their codes that were reviewed over 15 years ago. The HCPAC Review Board concurred with this request.

AMA/Specialty Society RVS Update Committee **Tab 29**
Administrative Subcommittee
December 2024 ***Via Email***

Members: Doctors James Waldorf (Chair), Clarice Sinn (Vice Chair), Kris Anderson, DC, MS, James Blankenship, Shannon Butkus, PhD, CCC-SLP, Peter Hollmann, Gwenn Jackson, Lance Manning, John McAllister, Carlo Milani, Amar Rewari, Christopher Senkowski, Nelda Spyres, LCSW, and Afnan Tariq.

I. Review Rotating Seat Election Rules and Candidates Nominated (RUC Agenda Tab 30)

The Subcommittee reviewed the nomination for the internal medicine rotating seat, Luke Barre, MD from the American College of Rheumatology (ACRh), and nominations for the any other rotating seat, Anne Miller, MD from the American Society of Surgery for the Hand (ASSH) and John T. Thompson, MD from the American Society of Retina Specialists (ASRS) .

The Administrative Subcommittee also reviewed the RUC rotating seat election rules. The Subcommittee noted that two candidates are nominated for the any other rotating seat, therefore one ballot will be issued and the candidate with the majority of votes will be elected to the seat. The Subcommittee noted that "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote," as is the case with the current internal medicine rotating seat election.

AMA/Specialty Society RVS Update Committee **Tab 06**
06 Coronary Therapeutic Services and Procedures
Facilitation Committee #1

Members: Margie Andreae, MD (Chair; PR), Amr Abouleish, MD, Jennifer Aloff, MD, John Heiner, MD, Matthew Grierson, MD, Kristopher Kimmell, MD, Richard Rausch, DPT, Kyle Richards, MD, James Waldorf, MD (PR)

The Facilitation Committee reviewed the family of 46 new lower extremity revascularization (LER) CPT codes. This code family includes 22 new 000-day global codes which are now differentiated between straightforward or complex lesions and cover 4 different vascular territories. It also includes 22 add-ons codes included for performing these services on additional vessels and 2 add-on codes for reporting intravascular lithotripsy(ies). There are codes specific to balloon transluminal angioplasty (TA), stent with TA, atherectomy with TA, stent and atherectomy with TA and lithotripsy of calcified vessels.

Prior to facilitation, the RUC voted on and passed codes 37254, 37255-37264, 37266-37272, 37288-37290 and 37296. The Facilitation Committee concurred with the RUC's prior recommendations for these codes. The recommendations for codes 37265, 37273 and 37274 did not pass the initial RUC vote – these three codes and the remainder of the code family were sent to facilitation.

Compelling Evidence
Prior to facilitation, the RUC discussed and approved compelling evidence based on a change in technology, change in patient population and change in site of service. The specialties noted that there have been significant changes to existing technology over the past 15 years including drug coated balloons, drug eluting stents, newer atherectomy devices, and advanced wires/catheters to treat more complex lesions. They also noted that this evolution of technology and techniques has allowed the expansion of endovascular revascularization to patients with more advanced disease and to more complex patients. Prior to 2010, the vast majority of lower extremity revascularization was performed in the hospital setting. Non-facility inputs created in 2010 allowed the migration of patient care out of the facility and into the non-facility setting as it became apparent that these procedures were able to be performed safely and more efficiently. The shift in site of service also results in compelling evidence for valuation. The Facilitation Committee acknowledged and supported this prior decision.

General Relativity
The presenters reviewed intra-family relativity across three main dimensions: straight forward to complex, proximal to distal territories, and increasing complexity of interventions. The presenters noted that the hierarchy of treatment modalities from simple to difficult is angioplasty < stent < atherectomy. They also noted that interventions increase in time and difficulty with progression from larger vessels to smaller vessels, i.e., iliac < femoral/popliteal < tibial < Inframalleolar.

Research-Approved Custom Survey Methodology
The Research Subcommittee approved a custom survey methodology which included conducting a standard RUC survey of 11 anchor codes for the family and then conduct an abbreviated survey for the other 36 codes. The 11 anchor codes represented every territory in the family, straightforward procedures, complex procedures, angioplasty only procedures, stent placement procedures, atherectomy procedures and add-on procedures.

Facilitation Committee Work Value and Physician Time Recommendations:

CPT Code	Short Descriptor	Results of Initial RUC Vote	Codes Individually Reviewed by Facilitation	Facilitation Work RVU	Facilitation IWPUT	Facilitation Work RVU Method	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra Time	Immed Post
37254	Iliac angio, init, SF	Y		7.30	0.097	25th	128	30	3	5	60	30
37255	+ Iliac angio, addl, SF	Y		3.00	0.100	25th	30				30	
37256	Iliac angio, init, CX	Y		10.75	0.116	25th	148	30	3	5	80	30
37257	+ Iliac angio, addl, CX	Y		3.89	0.108	25th	36				36	
37258	Iliac angio, stent, init, SF	Y		8.75	0.097	25th	143	30	3	5	75	30
37259	+ Iliac angio, stent, addl, SF	Y		4.00	0.100	25th	40				40	
37260	Iliac angio, stent, init, CX	Y (after reduction)		12.69	0.096	25th	185	30	3	5	117	30
37261	+ Iliac angio, stent, addl, CX	Y (after reduction)		4.25	0.097	25th	44				44	
37262	+ Iliac IVL	Y		3.00	0.100	25th	30				30	
37263	Fem-Pop angio, init, SF	Y (after reduction)		7.75	0.105	X-Walk to 37211 (below 25th)	128	30	3	5	60	30
37264	+ Fem-Pop angio, addl, SF	Y		3.00	0.100	25th	30				30	
37265	Fem-Pop angio, init, CX	N	**X (reduction)**	10.50	0.101	25th	158	30	3	5	90	30

CPT Code	Short Descriptor	Results of Initial RUC Vote	Codes Individually Reviewed by Facilitation	Facilitation Work RVU	Facilitation IWPUT	Facilitation Work RVU Method	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra Time	Immed Post
37266	+ Fem-Pop angio, addl, CX	Y		4.00	0.100	25th	40				40	
37267	Fem-Pop angio, stent, init, SF	Y		8.75	0.097	25th	143	30	3	5	75	30
37268	+ Fem-Pop angio, stent, addl, SF	Y		3.73	0.107	25th	35				35	
37269	Fem-Pop angio, stent, init, CX	Y		14.75	0.121	25th	178	30	3	5	110	30
37270	+ Fem-Pop angio, stent, addl, CX	Y (after reduction)		5.00	0.096	25th	52				52	
37271	Fem-Pop angio, ather, init, SF	Y		9.00	0.084	25th	158	30	3	5	90	30
37272	+ Fem-Pop angio, ather, addl, SF	Y		4.00	0.093	25th	43				43	
37273	Fem-Pop angio, ather, init, CX	N	**X (reduction)**	12.63	0.095	25th	186	30	3	5	118	30
37274	+ Fem-Pop angio, ather, addl, CX	N	**X (reduction)**	5.50	0.092	25th	60				60	

CPT Code	Short Descriptor	Results of Initial RUC Vote	Codes Individually Reviewed by Facilitation	Facilitation Work RVU	Facilitation IWPUT	Facilitation Work RVU Method	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra Time	Immed Post
37275	Fem-Pop angio, stent, ather, init, SF		**X**	11.00	0.083	25th	183	30	3	5	115	30
37276	+ Fem-Pop angio, stent, ather, addl, SF		**X**	4.25	0.094	X-Walk to 37237 (below 25th)	45				45	
37277	Fem-Pop angio, stent, ather, init, CX		**X (reduction)**	15.00	0.110	X-Walk to 93653 (between 25th and Med)	191	30	3	5	123	30
37278	+ Fem-Pop angio, stent, ather, addl, CX		**X (reduction)**	6.00	0.100	25th	60				60	
37279	+ Fem-Pop IVL		**X**	4.00	0.100	Median	40				40	
37280	Tib-Per angio, init, SF		**X**	9.80	0.093	25th	158	30	3	5	90	30
37281	+ Tib-Per angio, addl, SF		**X**	3.00	0.100	X-Walk to 47543 (below 25th)	30				30	
37282	Tib-Per angio, init, CX		**X**	12.31	0.109	X-Walk to 92943 (between 25th and Med)	168	30	3	5	100	30
37283	+ Tib-Per angio, addl, CX		**X (reduction)**	4.26	0.095	25th	45				45	

CPT Code	Short Descriptor	Results of Initial RUC Vote	Codes Individually Reviewed by Facilitation	Facilitation Work RVU	Facilitation IWPUT	Facilitation Work RVU Method	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra Time	Immed Post
37284	Tib-Per angio, stent, init, SF		**X**	10.00	0.085	25th	168	30	3	5	100	30
37285	+ Tib-Per angio, stent, addl, SF		**X**	3.34	0.095	X-Walk to 35686 (below 25th)	35				35	
37286	Tib-Per angio, stent, init, CX		**X (reduction)**	13.46	0.100	X-Walk to 49594 (between 25th and Med)	188	30	3	5	120	30
37287	+ Tib-Per angio, stent, addl, CX		**X (reduction)**	5.00	0.100	25th	50				50	
37288	Tib-Per angio, ather, init, SF	Y		13.50	0.100	25th	188	30	3	5	120	30
37289	+ Tib-Per angio, ather, addl, SF	Y		4.75	0.106	25th	45				45	
37290	Tib-Per angio, ather, init, CX	Y		17.00	0.104	25th	218	30	3	5	150	30
37291	+ Tib-Per angio, ather, addl, CX		**X (reduction)**	6.50	0.108	X-Walk to 34709 (between 25th and Med); supported by ref code 96547	60				60	
37292	Tib-Per angio, stent, ather, init, SF		**X (increase)**	15.00	0.095	Median	210	30	3	5	142	30

CPT Code	Short Descriptor	Results of Initial RUC Vote	Codes Individually Reviewed by Facilitation	Facilitation Work RVU	Facilitation IWPUT	Facilitation Work RVU Method	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra Time	Immed Post
37293	+ Tib-Per angio, stent, ather, addl, SF		**X**	6.50	0.108	25th	60				60	
37294	Tib-Per angio, stent, ather, init, CX		**X**	18.00	0.097	Median	238	30	3	5	170	30
37295	+ Tib-Per angio, stent, ather, addl, CX		**X (reduction)**	8.16	0.109	X-Walk to 34833 (between 25th and Med); supported by ref code 22853	75				75	
37296	Inframalleolar angio, init, SF	Y		11.00	0.095	25th	168	30	3	5	100	30
37297	+ Inframalleolar angio, addl, SF		**X**	4.00	0.100	25th	40				40	
37298	Inframalleolar angio, init, CX		**X (reduction)**	13.70	0.102	X-Walk to 49621 (between 25th and Med)	188	30	3	5	120	30
37299	+ Inframalleolar angio, addl, CX		**X**	5.00	0.111	Median	45				45	

Practice Expense
The Facilitation Committee acknowledged and supported the prior recommendations made by the Practice Expense Subcommittee. The only modification made by the Practice Expense Subcommittee to the direct PE inputs originally recommended by the presenting societies was to remove 4 supplies to avoid overlap with moderate sedation services that are separately reportable. The supplies removed were SC001 *angiocatheter 14g-24g*, SG037 *dressing, 4in x 4.75in (Tegaderm)*, SC018 *iv infusion set* and SA019 *kit, iv starter*.

New Technology
The two intravascular lithotripsy (IVL) CPT codes 37262 and 37279 will be placed on the New Technology list to be reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

SS Rec Summary

ISSUE: Lower Extremity Revascularization (LER)

TAB: 6

Source	CPT	DESC	Global	RUC Year	Resp	IWPUT	WPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt or obs/disch 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	22	0.106	0.071			9.00			126	22	4	5			75			20																
2nd REF	36253	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography,	000	2011	19	0.100	0.060			7.30			121	23	3	5			60			30																
CURRENT	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	000	2010	129	0.107	0.062			7.90			128	30	3	5			60			30																
SVY	37254	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	000		113	0.112	0.055	3.50	7.30	8.75	11.25	25.00	159	45	10	14	15	40	60	80	180	30												0	5	11	25	50
REC (core code)	37254	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	000			0.097	0.057			7.30			128	30	3	5			60			30																
1st REF	37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or	ZZZ	2016	29	0.117	0.117			3.50			30						30																			
2nd REF	34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal	ZZZ	2017	22	0.108	0.108			6.50			60						60																			
CURRENT	37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to	ZZZ	2010	79	0.092	0.089			3.73			42	1					40			1																
SVY	37255	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ		113	0.133	0.133	2.50	3.00	4.00	6.13	24.39	30				6	15	30	45	180														0	4	8	17	50
REC (core code)	37255	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ			0.100	0.100			3.00			30						30																			
1st REF	36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	23	0.104	0.074			10.42			141	22	4	5			90			20																
2nd REF	61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic	000	2015	18	0.121	0.062			15.00			241	40	3	15			100			83																
CURRENT	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	000	2010	129	0.107	0.062			7.90			128	30	3	5			60			30																
SVY	37256	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	000		113	0.161	0.083	3.00	10.75	14.87	15.80	26.78	180	45	10	15	20	60	80	100	208	30												0	4	8	24	50
REC (core code)	37256	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	000			0.116	0.073			10.75			148	30	3	5			80			30																
Comparator	37255	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ			0.100	0.100			3.00			30						30																			
CURRENT	37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to	ZZZ	2010	79	0.092	0.089			3.73			42	1					40			1																
SVY	37257	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ		48	0.172	0.172	3.00	3.89	6.20	8.14	24.39	36				10	20	36	60	119														0	2	5	9	100
REC	37257	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ			0.108	0.108			3.89			36						36			0																
Comparator	37254	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	000			0.097	0.057			7.30			128	30	3	5			60			30																
CURRENT	37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the	000	2010	126	0.092	0.062			9.75			158	30	3	5			90			30																
SVY	37258	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when	000		48	0.104	0.057	4.50	8.75	9.75	10.00	16.00	170	40	10	15	25	46	75	90	210	30												0	4	5	11	100
REC	37258	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when	000			0.097	0.061			8.75			143	30	3	5			75			30																

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
33																																								
34	Comparator	37255	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ			0.100	0.100			3.00			30						30																					
35	CURRENT	37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel when performed (List separately	ZZZ	2010	79	0.093	0.090			4.25			47	1					45			1																	
36	SVY	37259	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for	ZZZ		48	0.131	0.131	2.00	4.00	5.25	7.06	15.00	40				10	20	40	48	120															0	2	5	10	110
37	REC	37259	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for	ZZZ			0.100	0.100			4.00			40						40																				
38																																							
39	Comparator	37256	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	000			0.116	0.073			10.75			148	30	3	5			80			30																	
40	CURRENT	37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the	000	2010	126	0.092	0.062			9.75			158	30	3	5			90			30																	
41	SVY	37260	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when	000		48	0.122	0.077	6.20	12.69	16.23	19.13	24.39	212	40	10	15	30	88	117	126	240	30													0	3	5	10	105
42	REC	37260	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when	000			0.096	0.069			12.69			185	30	3	5			117			30																	
43																																							
44	Comparator	37255	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and	ZZZ			0.100	0.100			3.00			30						30																					
45	CURRENT	37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty	ZZZ	2010	79	0.093	0.090			4.25			47	1					45			1																	
46	SVY	37261	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when	ZZZ		48	0.114	0.114	3.80	4.25	5.00	7.50	18.00	44				15	30	44	60	149															0	2	4	9	115
47	REC	37261	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when	ZZZ			0.097	0.097			4.25			44						44																					
48																																							
49	1st REF	36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological	ZZZ	2016	21	0.106	0.106			4.25			40						40																					
50	2nd REF	37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or	ZZZ	2016	19	0.117	0.117			3.50			30						30																					
51	CURRENT	37799	Unlisted procedure, vascular surgery				#DIV/0!	#DIV/0!						0																											
52	SVY	37262	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the	ZZZ		113	0.150	0.150	2.00	3.00	4.50	7.00	24.39	30				8	20	30	58	180															0	2	5	11	50
53	REC (core code)	37262	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the	ZZZ			0.100	0.100			3.00			30						30																					
54																																							
55	Comparator	37267	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.097	0.061			8.75			143	30	3	5			75			30																	
56	CURRENT	37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	000	2010	89	0.091	0.059			8.75			148	30	3	5			80			30																	
57	SVY	37263	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	000		48	0.135	0.065	4.75	8.43	10.00	13.81	24.39	155	40	10	15	20	40	60	90	240	30													0	4	10	20	115
58	XWALK	37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment	000			0.105	0.061			7.75			128	30	3	5			60			30																	
59	REC	37263	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	000			0.105	0.061			7.75			128	30	3	5			60			30																	
60																																							
61	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																					

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
62	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
63	SVY	37264	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	ZZZ		48	0.167	0.167	2.00	3.00	5.00	8.16	16.00	30				6	20	30	48	119														0	3	8	20	120
64	REC	37264	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	ZZZ			0.100	0.100			3.00			30						30																				
65																																							
66	Comparator	37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.121	0.083			14.75			178	30	3	5			110			30																	
67	CURRENT	37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	000	2010	89	0.091	0.059			8.75			148	30	3	5			80			30																	
68	SVY	37265	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	000		48	0.112	0.065	6.10	10.50	12.00	14.36	24.00	185	40	10	15	20	65	90	120	240	30													0	5	8	23	105
69	REC	37265	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	000			0.101	0.066			10.50			158	30	3	5			90			30																	
70																																								
71	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
72	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
73	SVY	37266	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	ZZZ		48	0.165	0.165	3.50	4.00	6.60	9.37	17.00	40				15	30	40	60	149														0	2	6	15	105
74	REC	37266	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers	ZZZ			0.100	0.100			4.00			40						40																				
75																																							
76	1st REF	36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	21	0.104	0.074			10.42			141	22	4	5			90			20																	
77	2nd REF	36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	19	0.106	0.071			9.00			126	22	4	5			75			20																	
78	CURRENT	37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the	000	2010	89	0.098	0.065			10.24			158	30	3	5			90			30																	
79	SVY	37267	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000		113	0.107	0.058	4.00	8.75	10.00	12.92	26.55	172	45	10	12	20	50	75	90	200	30													0	8	19	46	150
80	REC (core code)	37267	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.097	0.061			8.75			143	30	3	5			75			30																	
81																																								
82	1st REF	36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological	ZZZ	2016	24	0.106	0.106			4.25			40						40																				
83	2nd REF	34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal	ZZZ	2017	21	0.108	0.108			6.50			60						60																				
84	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
85	SVY	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ		113	0.186	0.186	2.50	3.73	6.50	9.50	24.39	35				8	20	35	61	210														0	5	10	23	50
86	REC (core code)	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
87																																								
88	1st REF	61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic	000	2015	28	0.121	0.062			15.00			241	40	3	15			100			83																	
89	2nd REF	36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	25	0.104	0.074			10.42			141	22	4	5			90			20																	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	RUC Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
90	CURRENT	37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the	000	2010	89	0.098	0.065			10.24			158	30	3	5			90			30																	
91	SVY	37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000		113	0.134	0.080	3.50	14.75	16.75	25.00	43.89	210	45	10	15	20	80	110	120	230	30													0	5	15	34	175
92	REC (core code)	37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.121	0.083			14.75			178	30	3	5			110			30																	
93																																								
94	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
95	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
96	SVY	37270	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ		48	0.135	0.135	3.90	5.00	7.00	9.67	17.00	52				15	35	52	70	130															0	3	8	18	105
97	REC	37270	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.096	0.096			5.00			52						52																				
98																																								
99	Comparator	37267	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.097	0.061			8.75			143	30	3	5			75			30																	
100	CURRENT	37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when	000	2010	82	0.087	0.063			11.75			186	30	3	5			118			30																	
101	SVY	37271	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	000		48	0.101	0.059	4.90	9.00	11.00	15.00	25.00	185	40	10	15	20	60	90	120	180	30													0	2	10	24	130
102	REC	37271	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	000			0.084	0.057			9.00			158	30	3	5			90			30																	
103																																								
104	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
105	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
106	SVY	37272	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	ZZZ		48	0.163	0.163	3.25	4.00	7.00	8.91	17.00	43				10	25	43	56	180															0	3	6	10	125
107	REC	37272	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	ZZZ			0.093	0.093			4.00			43						43																				
108																																								
109	Comparator	37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.121	0.083			14.75			178	30	3	5			110			30																	
110	CURRENT	37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when	000	2010	82	0.087	0.063			11.75			186	30	3	5			118			30																	
111	SVY	37273	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	000		48	0.111	0.071	5.25	12.63	15.03	20.00	36.25	213	40	10	15	20	75	118	151	240	30													0	3	5	25	120
112	REC	37273	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	000			0.095	0.068			12.63			186	30	3	5			118			30																	
113																																								
114	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
115	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
116	SVY	37274	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	ZZZ		48	0.117	0.117	3.95	5.50	7.00	10.00	18.00	60				11	30	60	70	210															0	2	5	15	125
117	REC	37274	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal	ZZZ			0.092	0.092			5.50			60						60																				

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4					RUC				RVW					Total	PRE-TIME			INTRA-TIME						IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
118																																								
119	Comparator	37267	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.097	0.061			8.75			143	30	3	5			75			30																	
120	CURRENT	37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes	000	2010	83	0.102	0.074			14.25			193	30	3	5			125			30																	
121	SVY	37275	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	000		48	0.109	0.069	4.50	11.00	14.45	19.86	35.00	210	40	10	15	30	74	115	150	240	30														0	2	5	10	105
122	REC	37275	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	000			0.083	0.060			11.00			183	30	3	5			115			30																	
123																																								
124	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
125	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
126	SVY	37276	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	ZZZ		48	0.156	0.156	3.25	5.00	7.00	10.00	18.36	45				10	28	45	74	180																0	1	5	10	115
127	XWALK	37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid,	ZZZ			0.093	0.090			4.25			47	1					45			1																	
128	REC	37276	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	ZZZ			0.094	0.094			4.25			45						45																				
129																																								
130	Comparator	37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	000			0.121	0.083			14.75			178	30	3	5			110			30																	
131	CURRENT	37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes	000	2010	83	0.102	0.074			14.25			193	30	3	5			125			30																	
132	SVY	37277	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	000		46	0.123	0.078	6.45	13.13	17.00	20.75	40.00	218	40	10	15	13	87	123	173	260	30														0	2	5	15	120
133	XWALK	93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing	000			0.112	0.075			15.00			199	31	3	15			120			30																	
134	REC	37277	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	000			0.110	0.079			15.00			191	30	3	5			123			30																	
135																																								
136	Comparator	37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal	ZZZ			0.107	0.107			3.73			35						35																				
137	CURRENT		N/A				#DIV/0!	#DIV/0!						0																										
138	SVY	37278	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	ZZZ		46	0.150	0.150	3.75	6.00	9.00	10.83	26.52	60				15	30	60	81	210																0	1	5	10	115
139	REC	37278	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal	ZZZ			0.100	0.100			6.00			60						60																				
140																																								
141	Comparator	37262	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the	ZZZ			0.100	0.100			3.00			30						30																				
142	CURRENT	37799	Unlisted procedure, vascular surgery				#DIV/0!	#DIV/0!						0																										
143	SVY	37279	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to	ZZZ		46	0.100	0.100	2.00	3.00	4.00	7.99	28.00	40				9	25	40	46	210																0	4	6	13	80
144	REC	37279	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to	ZZZ			0.100	0.100			4.00			40						40																				
145																																								
146	Comparator	37288	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.100	0.072			13.50			188	30	3	5			120			30																	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	RUC Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
147	CURRENT	37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	000	2010	74	0.103	0.068			10.75			158	30	3	5			90			30																
148	SVY	37280	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000		46	0.098	0.056	5.00	9.80	11.00	16.97	22.60	196	47	14	15	22	60	90	108	200	30													2	20	25	40	250
149	REC	37280	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.093	0.062			9.80			158	30	3	5			90			30																
150																																							
151	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				
152	CURRENT	37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in	ZZZ	2010	64	0.099	0.095			4.00			42	1					40			1																
153	SVY	37281	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ		46	0.133	0.133	2.00	3.50	4.00	8.00	20.00	30				11	20	30	59	180															0	10	18	30	250
154	XWALK	47543	Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated	ZZZ			0.100	0.100			3.00			30						30																				
155	REC	37281	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ			0.100	0.100			3.00			30						30																				
156																																							
157	Comparator	37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.104	0.078			17.00			218	30	3	5			150			30																
158	CURRENT	37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	000	2010	74	0.103	0.068			10.75			158	30	3	5			90			30																
159	SVY	37282	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000		46	0.128	0.073	6.75	10.00	15.00	20.00	32.89	206	47	14	15	30	90	100	120	220	30													1	10	20	30	300
160	XWALK	92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of	000			0.120	0.082			12.31			151	23	1	5			92			30																
161	REC	37282	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.109	0.073			12.31			168	30	3	5			100			30																
162																																							
163	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				
164	CURRENT	37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in	ZZZ	2010	64	0.099	0.095			4.00			42	1					40			1																
165	SVY	37283	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ		46	0.143	0.143	3.00	4.26	6.45	10.00	25.00	45				15	30	45	74	180															0	5	12	30	250
166	REC	37283	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ			0.095	0.095			4.26			45						45																				
167																																							
168	Comparator	37288	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.100	0.072			13.50			188	30	3	5			120			30																
169	CURRENT	37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty	000	2010	72	0.101	0.072			13.55			188	30	3	5			120			30																
170	SVY	37284	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	000		46	0.118	0.068	6.55	10.00	14.00	19.00	35.00	206	47	14	15	30	75	100	120	220	30													0	1	10	22	50
171	REC	37284	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	000			0.085	0.060			10.00			168	30	3	5			100			30																
172																																							
173	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				
174	CURRENT	37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes	ZZZ	2010	59	0.091	0.089			5.50			62	1					60			1																

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
175	SVY	37285	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	ZZZ		46	0.171	0.171	2.00	4.05	6.00	10.00	25.00	35				10	25	35	71	180														0	0	5	22	50
176	XWALK	35686	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)	ZZZ			0.095	0.095			3.34			35						35																				
177	REC	37285	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	ZZZ			0.095	0.095			3.34			35						35																				
178																																								
179	Comparator	37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.104	0.078			17.00			218	30	3	5			150			30																	
180	CURRENT	37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty	000	2010	72	0.101	0.072			13.55			188	30	3	5			120			30																	
181	SVY	37286	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	000		46	0.107	0.066	7.00	11.10	15.00	21.00	40.00	226	47	14	15	30	90	120	135	235	30														0	1	9	20	50
182	XWALK	49594	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of	000			0.094	0.060			13.46			225	35	15	15			120			40																	
183	REC	37286	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	000			0.100	0.072			13.46			188	30	3	5			120			30																	
184																																								
185	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				
186	CURRENT	37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes	ZZZ	2010	59	0.091	0.089			5.50			62	1					60			1																	
187	SVY	37287	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty	ZZZ		46	0.154	0.154	2.00	5.00	7.68	12.38	35.00	50				15	30	50	90	180															0	0	5	13	50
188	REC	37287	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty				0.100	0.100			5.00			50						50																				
189																																								
190	1st REF	61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic	000	2015	23	0.121	0.062			15.00			241	40	3	15			100			83																	
191	2nd REF	36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	19	0.104	0.074			10.42			141	22	4	5			90			20																	
192	CURRENT	37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same	000	2010	68	0.103	0.073			13.80			188	30	3	5			120			30																	
193	SVY	37288	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000		113	0.136	0.083	5.00	13.50	18.34	29.50	40.00	220	45	11	14	20	70	120	120	250	30														0	6	13	29	200
194	REC (core code)	37288	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.100	0.072			13.50			188	30	3	5			120			30																	
195																																								
196	1st REF	34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal	ZZZ	2017	23	0.108	0.108			6.50			60						60																				
197	2nd REF	37186	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or	ZZZ	2005	16	0.082	0.082			4.92			60						60																				
198	CURRENT	37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same	ZZZ	2010	58	0.108	0.105			6.50			62	1					60			1																	
199	SVY	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ		113	0.133	0.133	3.00	4.75	6.00	7.50	30.00	45				1	23	45	75	210															0	2	10	25	150
200	REC (core code)	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				
201																																								
202	1st REF	61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic	000	2015	22	0.121	0.062			15.00			241	40	3	15			100			83																	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4									RVW					Total	PRE-TIME			INTRA-TIME						IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	RUC Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
203	2nd REF	36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	20	0.104	0.074			10.42			141	22	4	5			90			20																	
204	CURRENT	37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same	000	2010	68	0.103	0.073			13.80			188	30	3	5			120			30																	
205	SVY	37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000		113	0.145	0.093	5.00	17.00	24.00	30.00	44.79	257	50	12	15	20	100	150	180	300	30													0	3	11	25	150
206	REC (core code)	37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.104	0.078			17.00			218	30	3	5			150			30																	
207																																								
208	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for	ZZZ			0.106	0.106			4.75			45						45																				
209	CURRENT	37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to	ZZZ	2010	58	0.108	0.105			6.50			62	1					60			1																	
210	SVY	37291	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for	ZZZ		46	0.158	0.158	3.00	5.50	9.48	14.94	41.89	60				25	45	60	90	200															0	1	7	30	140
211	XWALK	34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer	000			0.108	0.108			6.50			60						60																				
212	REC	37291	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for	ZZZ			0.108	0.108			6.50			60						60																				
213																																								
214	Comparator	37288	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.100	0.072			13.50			188	30	3	5			120			30																	
215	CURRENT	37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy,	000	2010	67	0.099	0.073			14.75			203	30	3	5			135			30																	
216	SVY	37292	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	000		46	0.090	0.060	4.50	10.00	15.00	18.00	43.44	248	47	14	15	30	100	142	180	315	30													0	0	5	25	80
217	REC	37292	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	000			0.095	0.071			15.00			210	30	3	5			142			30																	
218																																								
219	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				
220	CURRENT	37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy,	ZZZ	2010	57	0.097	0.095			7.80			82	1					80			1																	
221	SVY	37293	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	ZZZ		46	0.133	0.133	4.00	6.50	8.00	14.00	45.00	60				20	30	60	71	200															0	0	3	25	50
222	REC	37293	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	ZZZ			0.108	0.108			6.50			60						60																				
223																																								
224	Comparator	37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	000			0.104	0.078			17.00			218	30	3	5			150			30																	
225	CURRENT	37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy,	000	2010	67	0.099	0.073			14.75			203	30	3	5			135			30																	
226	SVY	37294	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	000		46	0.093	0.065	5.00	12.25	18.00	23.25	50.00	276	47	14	15	30	120	170	200	330	30													0	0	2	25	130
227	REC	37294	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	000			0.097	0.076			18.00			238	30	3	5			170			30																	
228																																								
229	Comparator	37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when	ZZZ			0.106	0.106			4.75			45						45																				

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
4					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt or obs/disch							Office					SURVEY EXPERIENCE				
5	Source	CPT	DESC	Global	Year	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
230	CURRENT	37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy,	ZZZ	2010	57	0.097	0.095			7.80			82	1					80			1																	
231	SVY	37295	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	ZZZ		46	0.120	0.120	4.00	6.20	9.03	15.30	34.54	75				20	45	75	90	200															0	0	2	20	95
232	XWALK	34833	Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal	000			0.113	0.113			8.16			72						72																				
233	REC	37295	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy,	ZZZ			0.109	0.109			8.16			75						75																				
234																																								
235	1st REF	61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic	000	2015	21	0.121	0.062			15.00			241	40	3	15			100			83																	
236	2nd REF	36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	000	2016	18	0.104	0.074			10.42			141	22	4	5			90			20																	
237	CURRENT	37799	Unlisted procedure, vascular surgery				#DIV/0!	#DIV/0!						0																										
238	SVY	37296	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000		113	0.120	0.070	3.50	11.00	14.00	17.85	41.67	199	45	10	14	20	75	100	135	300	30													0	1	5	19	100
239	REC (core code)	37296	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.095	0.065			11.00			168	30	3	5			100			30																	
240																																								
241	Comparator	37296	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.095	0.065			11.00			168	30	3	5			100			30																	
242	CURRENT	37799	Unlisted procedure, vascular surgery				#DIV/0!	#DIV/0!						0																										
243	SVY	37297	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ		46	0.113	0.113	2.00	4.00	4.50	10.00	32.76	40				8	30	40	90	200															0	2	5	22	70
244	REC	37297	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ			0.100	0.100			4.00			40						40																				
245																																								
246	Comparator	37296	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.095	0.065			11.00			168	30	3	5			100			30																	
247	CURRENT	37799	Unlisted procedure, vascular surgery				#DIV/0!	#DIV/0!						0																										
248	SVY	37298	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000		46	0.107	0.066	5.00	10.50	15.00	18.00	42.91	226	47	14	15	20	98	120	150	320	30													0	2	3	20	65
249	XWALK	49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed;	000			0.097	0.062			13.70			220	40	15	15			120			30																	
250	REC	37298	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.102	0.073			13.70			188	30	3	5			120			30																	
251																																								
252	Comparator	37296	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	000			0.095	0.065			11.00			168	30	3	5			100			30																	
253	CURRENT	37799	Unlisted procedure, vascular surgery				#DIV/0!	#DIV/0!						0																										
254	SVY	37299	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ		46	0.111	0.111	2.00	4.00	5.00	10.00	36.39	45				10	30	45	81	200															0	0	2	20	50
255	REC	37299	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for	ZZZ			0.111	0.111			5.00			45						45																				