**AMA/Specialty Society RVS Update Committee**
**The Fairmont Century Plaza Hotel, Los Angeles, CA**
**January 14-17, 2026**

**Meeting Minutes**

## I. Welcome and Call to Order

The RUC met in person in January 2026. Doctor Ezequiel Silva III called the meeting to order on Thursday, January 15, 2026, at 10:34 a.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
Luke Barré, MD
James Blankenship, MD
Audrey Chun, MD
Joseph Cleveland, MD
Gregory DeMeo, DO
Leisha Eiten, AuD
Alexandra Flamm, MD
Matthew J. Grierson, MD
Gregory Harris, MD, MPH
Peter Hollmann, MD
M. Douglas Leahy, MD
Scott Manaker, MD
Bradley Marple, MD
John McAllister, MD
Swati Mehrotra, MD
Anne Miller, MD
Gregory Nicola, MD
John Proctor, MD
Kyle Richards, MD
Donald J. Selzer, MD
Lawrence Simon, MD
Mark T. Villa, MD
Thomas J. Weida, MD
Robert Zipper, MD

**RUC Alternates:**
Megan Adamson, MD
Anita Arnold, DO
Eileen Brewer, MD
Neal Cohen, MD
Daniel Duzan, MD
Patrick Godbey, MD
Martha Gray, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kevin Kerber, MD
Kristopher Kimmell, MD
Thomas Kintanar, MD
Timothy Laing, MD
Mollie MacCormack, MD
Lance Manning, MD
Lauren Nicola, MD
Michael Perskin, MD
Noah Raizman, MD
Sanjay Samy, MD
Christopher Shale, MD
James Shoemaker, MD
Clarice Sinn, DO
Michael Sutherland, MD
Timothy Swan, MD
Thomas Turk, MD
Korinne Van Keuren, DNP
David Vollman, MD
David Yankura, MD
Robert Zwolak, MD

## II. Chair's Report

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

- Doctor Silva 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:
  - Sarah Abshier, DPM – CPT Panel Member
  - Samuel L. Church, MD – CPT Panel Member
  - Lawrence Simon, MD – CPT Panel Member
  - Timothy Swan, MD – CPT Panel Member

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) attendees:
  - Lindsey Baldwin – Director, Div of Practitioner Services
  - Stefanie Fischell, MD – Medical Officer
  - Edith Hambrick, MD – Medical Officer
  - Michael Soracoe, PhD – Technical Advisor

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) virtual attendees:
  - Perry Alexion, MD
  - Erick Carrera, JD
  - Morgan Kitzmiller
  - Sarah Leipnik
  - Mikayla Murphy
  - Maya Peterson
  - Terry Simananda
  - Pam West

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

- Doctor Silva welcomed the AMA Board of Trustees Chair:
  - David H. Aizuss, MD, Chair

- Doctor Silva recognized new RUC members:
  - John McAllister, MD – American Academy of Ophthalmology (AAO)
  - Don Selzer, MD, FACS – American College of Surgeons (ACS)

- Doctor Silva recognized a new RUC Alternate:
  - David Vollman, MD, MBA – American Academy of Ophthalmology (AAO)

- Doctor Silva recognized dedicated and departing RUC members:
  - Jennifer Aloff, MD – Primary Care Rotating Seat
  - Christopher Senkowski, MD – ACS
  - Robert Zipper, MD – Society of Hospital Medicine (SHM)

- Doctor Silva acknowledged the Rotating Seat Elections:
  - Saturday, January 17, 2026 @ 8am PT
  - Internal Medicine Rotating Seat
    - Elizabeth Blanchard, MD – American Society of Clinical Oncology (ASCO)
  - Primary Care Rotating Seat
    - Michael Perskin, MD – American Geriatrics Society (AGS)

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

- Doctor Silva shared the following procedural issues for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue, and it will be reflected in the minutes.

  - RUC members or alternates sitting at the table may not present or debate for their society.
  - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.

- Doctor Silva conveyed the following procedural guidelines related to voting for the RUC:
  - Work RVU and Direct Practice Expense Inputs = 2/3 vote
  - Motions = Majority vote
  - RUC members will vote on all tabs using the single voting link provided via email (Qualtrics).
  - You will need to have access to a computer or smartphone to submit your vote.
  - If you are unable to vote during the meeting, please notify AMA staff.
  - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports.
  - If members are going to abstain from voting, please notify AMA staff so that all 29 votes can be accounted for.
  - If specialty society presenters require time to deliberate, please notify the RUC Chair.
  - If RUC advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC chair or AMA staff.

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

- Doctor Silva relayed the following procedural guideline relating to New Business:
  - Throughout this meeting, if you have potential items for new business, please let AMA staff and/or the RUC Chair know so we may guide you to existing resources, if applicable.

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

- Doctor Silva discussed the Electronic Health Record (EHR) Data Collection Pilot Project:
  - In September 2025, the Research Subcommittee received a presentation from Nate Apathy, PhD, Assistant Professor of Health Policy & Management at the University of Maryland School of Public Health, on the use of EHR audit log data to estimate service/procedure time.
  - The AMA has contracted with Dr. Apathy and researchers at the University of California San Francisco to conduct a pilot study to determine if EHR audit log data is sufficient to verify the RUC standard clinical staff time for vital signs and physician time for documentation of procedures.
  - A subgroup of the Research Subcommittee and the Chair of the PE Subcommittee will serve as a clinical expert panel on the project. We anticipate that the status of the effort will be discussed with the Research Subcommittee at the April 2026 RUC meeting.

## III. Director's Report

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

- Ms. Smith reviewed the RUC Database 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 2024 Medicare claims data and 2026 Non-APM Conversion Factor (CF).
  - Includes more specific Do Not Use to Validate Physician Work flags.
  - The 2026 work RVUs as published by CMS (with the efficiency adjustment).
  - The 2026 physician time as published by CMS (without the efficiency adjustment). CMS did NOT adjust physician intra-service time in their time files. The adjustments were to total time in a secondary field to the regularly published total time. Therefore, the RUC Database includes the 2026 unadjusted intra-service and total times.
  - The Intra-service Work Per Unit of Time (IWPUT) is automatically calculated and it was calculated, as always, from the CMS published data.
  - Will incorporate new fields in programming for next RUC database update.
  - The AMA is working with the Research Data Assistance Center (RESDAC) to obtain Medicaid and Medicare Advantage data. We hope to include these data in the RUC database in the future. The current database includes 2012 Medicaid data.

- 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 |
|---|---|---|---|
| Mar 31, 2026 | Apr 23-25, 2026 | Chicago, IL | CPT 2028 |
| Aug 25, 2026 | Sep 24-26, 2026 | Chicago, IL | CPT 2028 |
| Dec 15, 2026 | Jan 20-23, 2027 | San Diego, CA | CPT 2028 |

- 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 23, 2026.
    - Once you have successfully completed the evaluation, a certificate will be automatically available on February 6, 2026, in the "Transcript" section of your AMA Ed Hub account.

## IV. Approval of Minutes from the September 2025 RUC Meeting

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

## V. CPT Editorial Panel Update

Lawrence M. Simon, MD, MBA, FACS, CPT Editorial Panel Member, provided the following CPT Editorial Panel update on the CPT Ad Hoc Workgroups, and upcoming CPT meeting:

- Upcoming CPT Panel Meeting Activity – February 2026
    - RUC Referrals to be reviewed at the February 2026 Panel Meeting:
        - Alcohol, Substance Abuse Assessment-Revise 99408, 99409 (Tab 5)
        - Central Venous Catheter Insertion Services (Tab 13)
        - Appendectomy (Tab 14)
        - Goniotomy (Tab 15)

- Notable Agenda Items
    - 13 Digital medicine related code change applications (CCAs)
    - 30 Category III code applications
    - 89 codes for Category III Sundown
    - 21 codes for CPT Code Set Maintenance

- CPT Editorial Panel Members
    - Panel Chair: Christopher L. Jagmin, MD
    - Panel Vice Chair: Barbara S. Levy, MD
    - The CPT Editorial Panel welcomed a new member:
        - Steven Goldberg, MD
            - Specialty: Orthopaedic Surgery
            - Panel Seat: National Medical Specialty

- February 2026 Panel Meeting
    - Child Maltreatment Services (Tab 4): Add new subsection in evaluation and management (E/M), new guidelines, and establish codes 99XX0, 99XX1 for child maltreatment services.
    - Alcohol, Substance Abuse Assessment-Revise 99408, 99409 (Tab 5*): Revise codes 99408, 99409 to add "assessment" and delete "screening."
    - Adjacent Tissue Transfer Guideline Revisions (Tab 6): Revise adjacent tissue transfer guidelines to allow reporting of excision of lesion with adjacent tissue transfer or rearrangement.

- Carpometacarpal Aspiration or Injection-Revise 20605 (Tab 7): Revise codes 20605, 20606 to allow reporting, including carpometacarpal (CMC) within the example description.
- Spine Deformity Guideline Revisions (Tab 8): Revise the Spine Deformity (e.g., Scoliosis, Kyphosis) guidelines and revise the exclusionary parentheticals for codes 22804, 22812, 22819, 22847, 22837, and 0657T.
- Extra-osseous Stabilization-Talotarsal Joint (Tab 10): Establish code 28XX0 to report extra-osseous stabilization of talotarsal joint.
- Non-Vascular Substernal Implantable Defibrillator Procedures (Tab 11): Delete Category III codes [0571T]-[0580T], [0614T]; establish Category I codes 332X1, 332X2, 332X3, 332X4 to report implantable cardioverter-defibrillator system with non-vascular substernal electrode; establish new sub-heading; and revise Category I codes [93260], [93261], [93644] and all related guidelines and parenthetical notes.
- Transcatheter Intracardiac Shunt Optimization-Revise 33745 (Tab 12): Revise codes 33745, 33746 to describe creation or optimization and to include pulmonary vein in the "e.g." parenthetical within the code descriptors.
- Central Venous Catheter Insertion Services (Tab 13*): Delete 36557, 36563; revise 36558, 36560, 36561, 36565, 36566; establish 36XX0-36X16 for tunneled central venous catheter procedures.
- Appendectomy (Tab 14*): Delete 44955; revise 44950, 44960; establish 44XX3-44X13 for open and laparoscopic appendectomy procedures.
- Goniotomy (Tab 15*): Revise 65820 to describe goniotomy in infant or child under 18 years old; establish 65XX0 to describe goniotomy in an adult.
- Open Posterior Tibial Neurostimulator Services (Tab 16): Establish codes 64X21, 64X22, 64X23, 64X24; delete codes 0816T, 0817T, 0818T, 0819T, 0988T, 0989T; revise guidelines and add parenthetical notes throughout the code set.

- CPT Ad Hoc Workgroups: Update - Digital Medicine Coding Committee (DMCC)
  - Co-Chairs: Richard Frank, MD, PhD, Mark Synovec, MD
    - Coding and Payment for Algorithmic Services Meeting (hybrid meeting) held on December 8th, 2025 at AMA Headquarters.
    - Appendix S revisions have been submitted as a CCA for the February 2026 CPT Panel meeting.
    - Advisors and Interested Parties are submitting comments.
    - Next Meetings: The workgroup will continue to meet virtually after the February Panel meeting.

- CPT Ad Hoc Workgroups: Update - Value Based Care (VBC) Services Workgroup
    - CCA Accepted at the September 2025 CPT Editorial Panel meeting marking the end of Phase 1.
    - Phase 2: Advance the CPT code set to reflect innovations in value-based care. The VBC Workgroup will guide efforts to modernize coding structures, such as episode-based models, to align with contemporary care delivery systems.
    - Next Steps: Meeting scheduled at the February 2026 Panel Meeting.

- Upcoming CPT Editorial Panel Meetings
  - The next Panel meeting is February 5-7, 2026 – Palm Springs, California
  - The next application submission deadline is February 9, 2026.

## VI. Centers for Medicare & Medicaid Services Update

Lindsey Baldwin, MA, Director of the Division of Practitioner Services, provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the CY 2026 Medicare Physician Payment Schedule (MFS) Final Rule.

- Ms. Baldwin noted that she is joined by her colleagues Dr. Edith Hambrick, Dr. Stefanie Fischell, Michael Soracoe, and others observing online.
- Ms. Baldwin remarked, "As always, I just want to emphasize how very much we appreciate the work that the RUC does, and the opportunity to observe your process."
- Ms. Baldwin then addressed the topics below:
    - CY 2026 PFS Rate-Setting/Conversion Factor
    - Efficiency Adjustment
    - Practice Expense
    - Telehealth
    - Comment Solicitation on Strategies for Improving Global Surgery Payment Accuracy
    - Policies to Improve Care for Chronic Illness and Behavioral Health Needs
    - Skin Substitutes

## VII. Contractor Medical Director Update

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

- How Does a Medicare Administrative Contractor (MAC) determine coverage when it is not explicitly defined by CMS?
    - We look at the evidence supporting it in our population
    - We start with the Food and Drug Administration's (FDA) definition of is it safe, and does it do what it says it will do
    - Will this service be "safe, effective, consistent with symptoms or diagnosis, and not experimental or investigational, aligning with accepted professional medical standards."(medical necessity as defined in The Social Security Act Section 1862(a)(1)(A))
    - We look at the peer reviewed literature supporting its use and evaluate the strength of the evidence
- How the evidence is evaluated
    - There are multiple tools and many of the MACs use the GRADE system, but there are also the Cochrane Risk of Bias Tool for assessing bias in Randomized Clinical Trials (RCTs), JBI Critical Appraisal Tools for various study types, the Newcastle-Ottawa Scale (NOS) for non-randomized studies, and the Risk of Bias in Systematic Reviews (ROBIS) tool for risk of bias in systematic reviews. Other resources include checklists from the Oxford Centre for Evidence-Based Medicine (OCEBM) and the Critical Appraisal Skills Program (CASP).
    - All these different tools attempt to provide a way of looking at evidence objectively minimizing bias.
    - When we evaluate evidence, we look at it in terms of the population served by Medicare (So child and young adult evidence is less supportive for a service or procedure in the Medicare population).

  - FDA approval is a factor, but the approval is evaluated for the indication for which the FDA approved it (if it is a device), and if a drug for the dose range and interval approved. (FDA approval does not confer coverage).
- Off Label use
  - Is not allowable for a device
  - But may be allowable for a drug or biological if supported by the Compendia or other strong evidence
- Upcoming Local Coverage Determinations (LCD's) and other Instructions
  - Comment Period Closed for the Following
    - DL39756 Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancer (NMSC)
    - DL40261 Peripheral Nerve Block Procedures
  - Contractors are interested in learning more about the status of cardiac lithotripsy and have already held a subject matter expert meeting. Please watch Contractor Websites for updates on Cardiac Lithotripsy
- Collaborative Workgroups
  - Skin brachytherapy-this policy will be visible very soon
  - Pain Management Peripheral Nerve Block-comment period closed reviewing comments and literature
  - Cardiology
    - Cardiac monitoring (Noridian, CGS, Palmetto)-comment period closed reviewing
    - Percutaneous lithotripsy (CGS, Noridian, NGS, Palmetto, WPS, Novitas/FC)-chair held a Contractor Advisory Committee (CAC) and do not plan to pursue policy at this time
  - Botulinum (CGS)-final complete and moving forward but not public yet
  - Allergy diagnostics policy to go to open in Feb
  - Waterjets-revision finalized (out on the websites for viewing)
  - Skin Substitute workgroup (need I say more?)
  - Hypoglossal nerve reactive -The Chair is chair working on the LCD reconsideration
  - iDose workgroup - collaborative (CGS, Noridian, NGS, Palmetto, WPS) - had CAC
  - Wound diagnostic modalities workgroup (CGS, Noridian, NGS, Palmetto, WPS)
- CMD Concerns
  - Skin Substitutes
    - There is still a lot of work to be done regarding the coverage and payment of non-sheet skin substitutes
    - There is no LCD
    - We are following CMS guidance and obtaining clarification when indicated
  - Artificial Intelligence
    - There is still an Artificial Intelligence (AI) Workgroup that is actively looking at ways to address how these services are covered (benefit category, etc.)
    - Different types, so hard to fit under one umbrella
- What the AMA Can Do to Help Us
  - When new CPT codes are developed, please make the descriptions as clear and specific as you can. (if not directly in the description, then in an assistant article)
  - It is difficult to define coverage, or price a service, if it is not clear what the components are.

**VIII. Washington Update**

Jennifer Hananoki, JD, Director, Federal Affairs, AMA, provided the Washington report focusing on AMA Advocacy on Medicare Physician and Qualified Health Professional (QHP) Payment, Merit-based Incentive Payment System (MIPS), and the Center for Medicare and Medicaid Innovation Center (CMMI) Payment Models. Please see full presentation attached for more details.

2026 Medicare Physician and Qualified Health Care Professional (QHP) Payment

- Medicare Conversion Factor
  - The updates include:
    - A temporary 2.5% pay bump passed by Congress in H.R. 1
    - Small, permanent updates to the baseline under Medicare Access and CHIP Reauthorization Act (MACRA) including:
      - 0.75% increase for qualified professionals (QPs)
      - 0.25% for all other physicians and qualified health plans (QHPs)
    - A positive 0.49% budget neutrality adjustment
- AMA Advocacy
  - We appreciate Congress provided a one-year 2.5% update in 2026
  - Aligning Medicare payments updates with Medicare economic index (MEI) allows practices to plan and invest without constant uncertainty
- Indirect Practice Expense (PE) Changes
  - CMS finalized a reduction in PE RVUs for services performed in a facility that resulted in an overall impact of
    - 7% cut to services performed in a facility
    - 4% bump for services performed in a non-facility
  - Significant impact on certain physicians within specialties representing a high ratio of private practice:
    - Gastroenterology – 53% more than a 5% cut
    - Obstetrics and Gynecology – 26% more than a 5% cut
    - Ophthalmology – 23% more than a 5% cut
    - Orthopaedic Surgery – 33% more than a 5% cut
- AMA Advocates for 4-Year Phase-In
  - Immediate cuts could destabilize practices, particularly affecting independent practices that deliver care in facilities
  - Concerned about unintended consequences, including accelerating the shift toward hospital, insurer, or private equity employment which is at odds with the Administration's goal to support private practice
  - Substantial precedent for phasing in payment redistributions, including for changes in clinical labor, supply and equipment costs, use of updated PE per hour data, and updates to GPCIs
  - Dec. 8, 2026, letter to CMS
- Efficiency Adjustment
  - CMS finalized a 2.5% decrease in work RVUs and physician intra-service time for most services, affecting nearly 7,000 physician services.
    - Exemptions: new 2026 codes; time-based services (such as E/M and care management), maternity care, and services on the telehealth list.
  - The efficiency adjustment is based on MEI productivity, but physicians still lack MEI-tied payment updates.

    - The AMA continues to oppose this policy and explore alternative approaches to accomplish CMS' goals of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care payment is adequate.
- Telehealth Updates
    - Virtual direct supervision is now permanently allowed, with no frequency limits for hospital/nursing facility visits or critical care via telehealth
    - Physicians may provide direct supervision remotely via video for most services (except those with 10- or 90-day global periods)
    - Virtual supervision for residents providing telehealth services is permitted in all training settings
    - Telehealth coverage extended to Jan. 30, 2026; payment delays and service disruptions occurred during the 2025 government shutdown
        - Mental health and substance use services continue
- AMA Advocacy: Telehealth
    - AMA urged CMS to resolve questions about requirements for physicians providing telehealth services from home to report their home address
    - CMS has responded that only physicians who have no practice location besides their home are required to do this, plus they can indicate they want their street address to be hidden from public view and it will be
    - New AMA Report: 71.4% of physicians reported using telehealth in their practices weekly in 2024, up from the 25.1% who reported that in 2018 before the pandemic
    - New AMA Issue Brief: The Case for Permanent Telehealth Policy and Expanded Access to Virtual Care

Merit-based Incentive Payment System (MIPS)

- Key Improvements for 2026
    - Stability and Predictability: CMS maintained the performance threshold at 75 points through the 2028 performance period
    - MIPS Value Pathways (MVPs): 6 new MVPs added and CMS adopted AMA's recommendation for alternative MVP frameworks using clinical groupings
    - Quality Measures Update: CMS revised the methodology to score administrative claims quality measures and identify "topped out" measures
    - Cost Feedback and Transparency: 2-year feedback period for cost measures allows clinicians to access data and improve performance before scores impact payments.
    - Support for Small Practices: Multispecialty groups with small practice status can continue group reporting, preserving flexibility for small and rural practices
- AMA Advocacy MIPS Reform
    - Streamlining Regulations: Reduce complex and burdensome requirements in MIPS, focusing on practical improvement for physicians.
    - Data Access: Timely access to MIPS performance data is needed to enable physicians to address care gaps and improve outcomes during the performance year.
    - Level the Playing Field: Ensure small, independent, and rural practices have the support necessary to succeed in MIPS.

Center for Medicare and Medicaid Innovation Center (CMMI) Payment Models

- Ms. Hananoki identified new physician and QHP Models including:
    - Wasteful and Inappropriate Service Reduction (WISeR)

  - Ambulatory Specialty Model (ASM)
  - Advancing Chronic Care with Effective, Scalable Solutions (ACCESS)
  - Making America Health Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA: ELEVATE)
  - Long-Term Enhanced Accountable Care Organization (ACO) Design (LEAD)
- LEAD Model
  - 10-year, voluntary model
  - Successor to ACO Realizing Equity, Access, and Community Health (REACH), begins 1/1/27
  - Risk-sharing and data-sharing with specialists
  - Add-on payment for rural providers
  - Listen to AMA's podcast with CMMI officials
- 2026 National Advocacy Conference
  - Feb. 23-25 in D.C. Preliminary agenda.
  - 2025 NAC highlights:
    - 8 members of Congress spoke to physicians at Pelosi Caucus Room
    - 7 members of Congress addressed the NAC 350 visits with House members and senators

## IX. Relative Value Recommendations for CPT 2027

**Skin Cell Suspension Autograft (Tab 4)**
**Taryn Travis, MD (ABA)**
**Facilitation Committee #3**

The RUC submitted recommendations to CMS for the CPT 2025 cycle for CPT codes 15011-15018. In the CY 2025 Proposed Rule, CMS stated that "contractor-pricing is appropriate for CPT codes 15011-15018 until reconsideration of the coding structure and re-survey is complete, given the concerning aspects of the CPT codes." The RUC understood that the involved specialty societies would submit an application for the CPT 2027 cycle. At the September 2025 CPT Editorial Panel meeting, four codes were created to report harvesting of epidermal and dermal skin, preparation of skin cell suspension autograft (SCSA), spray application of SCSA, and dressing with fixation with a unit of service of the first 100 sq cm or less, or 1% of body area of infants and children. The existing eight codes were deleted, and the "Skin Cell Suspension Autograft" guidelines were revised. The four new codes were surveyed for the January 2026 RUC meeting.

**15X19** ***Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; first 100 sq cm or less, or 1% of body area of infants and children***
The RUC reviewed the survey results from 49 burn surgeons and determined that the survey median work RVU of 10.97 appropriately accounts for the physician work involved in this service. The RUC recommends 45 minutes pre-service evaluation time, 16 minutes pre-service positioning time, 12 minutes pre-service scrub/dress/wait time, 65 minutes intra-service time, 25 minutes immediate post-service time, 7-99232 subsequent hospital inpatient visits, 1-99239 discharge visit, 1-99214 and 3-99213 post-operative office visits. This base code for the first 100 sq cm is typically reported with 19 units of the new add-new code (15X20) and will include all of the bundled post-operative visits for the typical patient. The typical operative (skin-to-skin) time for this entire procedure (one base code and 19 add-on codes) was determined to be 3 hours by an expert panel. This time was clarified as distinct from any procedures performed during the same operative session.

The RUC discussed the pre-service times and justified the deviations from the facility pre-service time package 4A for difficult patient/difficult procedure. The specialty recommends 5 additional minutes of pre-service evaluation time for the complicated counseling involved in the procedure; 13 additional minutes of pre-service positioning time for the difficult positioning and repositioning of the burn patient; and 8 fewer minutes of pre-service scrub/dress/wait time.

The RUC noted that several inpatient facility visits plus a discharge visit are required for the typical patient. Patients are typically in serious condition and at high risk for potentially fatal complications, requiring extensive care before discharge. Therefore, the inpatient and outpatient visits were determined to be appropriate for this critically ill patient population.

The RUC determined that the post-operative visits supported by the survey were appropriate, as these burn patients require a higher level of post-operative care. Following SCSA procedures, several post-op office visits are required for burn wound patients, which include the following:

- Monitoring healing
- Multiple dressing changes
- Managing pain
- Return to work and activity counseling
- Assessing for possible infection
- Concomitant medication management
- Assessing compliance with therapy (PT/OT)
- Monitoring nutritional status and dietary intake

Additionally, all post-discharge office visits for this procedure, including changing dressings and providing antibiotic and pain medication adjustments, for 90 days after the day of the operation, are considered part of the postoperative work for this procedure.

The RUC expressed concern regarding the negative IWPUT for the two base codes: 15X19 (-0.109) and 15X21 (-0.098). However, the RUC did not agree with adjusting the post-operative visits to resolve this negative IWPUT issue and were convinced that the number and intensity of post-operative visits should be maintained. The RUC concurred that the procedure could be considered as a whole:

> *The base code 15X19 and the 19 units of add-on code 15X20 equates to approximately 180 minutes of intra-service time (65+(6*19) and 22.18 total RVUs (10.97+(0.59*19) which results in a positive IWPUT of 0.023.*

The RUC noted that these services would typically be reported with other services such as wound bed preparation and other grafts. Multiple procedure reduction was felt adequate to address this. To support the median value for CPT code 15X19, the RUC compared the surveyed code to the top key reference service 15110 *Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children* (work RVU = 10.70, 50 minutes pre-service time, 28 minutes intra-service time, 20 minutes immediate post-service time, 4-99232 and 3-99212) and noted that the epidermal autograft is a comparable service but requires less intra-service time and is therefore appropriately valued less than the surveyed code.

For additional support, the RUC compared the surveyed code to MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.00, 30 minutes pre-service time, 60 minutes intra-service time, 15 minutes immediate post-service time, 2-99212, and 2-99213) and 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.16, 58 minutes pre-service time, 90 minutes intra-service time,

17.5 minutes immediate post-service time, 0.5-99238, 3-99212, and 1-99213) and noted that the comparison codes appropriately bracket the recommendation. The RUC concluded that CPT code 15X19 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 10.97 for CPT code 15X19.**

**15X20** ***Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 burn surgeons and determined that a direct work RVU crosswalk to CPT code 77063 *Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)* (work RVU = 0.59, 8 minutes intra-service time) maintains relativity within the code family and appropriately accounts for the physician work required for the additional graft application component.

The RUC determined that 19 units of the add-code 15X20 are typically reported with the base code 15X19. The typical operative (skin-to-skin) time for the complete procedure, including the base code and add-on codes was estimated to be 3 hours. The RUC discussed the survey times and agreed that the times for the add-on code were neither representative nor realistic. Therefore, **the RUC recommends 6 minutes of intra-service time for the add-on code derived as follows**:

*180 minutes operative time – 65 minutes intra-service time of base code = 115/19 typical units = 6.05 minutes.*

To justify a work RVU of 0.59, the RUC compared CPT code 15X20 to CPT code 15274 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.78, 10 minutes intra-service time) noting that the application code requires more intra-service time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC referenced CPT code 11103 *Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)* (work RVU = 0.37, 6 minutes intra-service time) and noted that the surveyed service has similar time but it more intense/complex than a biopsy. **The RUC recommends a work RVU of 0.59 for CPT code 15X20.**

**15X21** ***Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children***
The RUC reviewed the survey results from 49 burn surgeons and determined that the survey median work RVU of 11.28 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes pre-service evaluation time, 16 minutes pre-service positioning time, 13 minutes pre-service scrub/dress/wait time, 85 minutes intra-service time, 25 minutes immediate post-service time, 1-99233 and 6-99232 subsequent hospital inpatient visits, 1-99239 discharge visit, 1-99214 and 4-99213 post-operative office visits. This base code for the first 100 sq cm is typically reported with 12 units of the new add-on code and will include all of the bundled post-operative visits for the typical patient. The typical operative (skin-to-skin) time for this procedure was determined to be 4 hours for the more sensitive areas of the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, and feet. This time was clarified as distinct from any procedures performed during the same operative session.

The RUC discussed the pre-service times and justified the deviations from the facility pre-service time package 4A for difficult patient/difficult procedure. The specialty recommends 5 additional minutes of pre-service evaluation time for the complicated counseling involved in the procedure; 13 additional minutes of pre-service positioning time for the difficult positioning and repositioning of the burn patient; and 7 fewer minutes of pre-service scrub/dress/wait time.

The RUC determined that both the inpatient and post-operative visits supported by the survey were appropriate, as these burn patients require a higher level of post-operative care. The RUC expressed concern regarding the negative IWPUT for the two base codes: 15X19 (-0.109) and 15X21 (-0.098). However, the RUC did not agree with adjusting the post-operative visits to resolve this IWPUT issue and were convinced that the number and intensity of post-operative visits should be maintained. The RUC concurred that the procedure could be considered as a whole:

> *The base code 15X21 and the 12 units of add-on code 15X22 equates to approximately 240 minutes of intra-service time (85+(13*12) and 23.04 total RVUs (11.28+(0.98*12) which results in a positive IWPUT of 0.014.*

To support the median value for CPT code 15X21, the RUC compared the surveyed code to the top key reference service 15115 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children* (work RVU = 11.00, 55 minutes pre-service time, 35 minutes intra-service time, 20 minutes immediate post-service time, 4-99232, 1-99238, and 3-99212) and noted that the epidermal autograft is a comparable service but requires much less intra-service time and is therefore appropriately valued less than the surveyed code.

For additional support, the RUC compared the surveyed code to MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.00, 30 minutes pre-service time, 60 minutes intra-service time, 15 minutes immediate post-service time, 2-99212, and 2-99213) and 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU = 13.16, 58 minutes pre-service time, 90 minutes intra-service time, 17.5 minutes immediate post-service time, 0.5-99238, 3-99212, and 1-99213) and noted that the comparison codes appropriately bracket the recommendation. The RUC concluded that CPT code 15X21 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 11.28 for CPT code 15X21.**

**15X22** ***Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 49 burn surgeons and determined that a direct work RVU crosswalk to CPT code 15278 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.98, 14 minutes intra-service time) maintains relativity within the code family and appropriately accounts for the physician work required for the additional graft application component in these sensitive areas.

The RUC determined that 12 units of the add-code 15X22 are typically reported with the base code 15X21. The typical operative (skin-to-skin) time for the base code procedure was estimated to be 4 hours. The RUC discussed the survey times and agreed that the times for the add-on code were not representative nor realistic. Therefore, **the RUC recommends 13 minutes of intra-service time for the add-on code derived as follows**:

*240 minutes operative time – 85 minutes intra-service time of base code = 155/12 typical units = 12.91 mins.*

The specialty noted that the rank order between the 15X20 and 15X22 was appropriate. Spray application is more complex than skin graft application when the placement is on the face and other areas included in 15X22.

To justify a work RVU of 0.98, the RUC compared CPT code 15X22 to CPT code 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.46, 15 minutes intra-service time) and noted that the dermal autograft is a comparable service that requires more intra-service time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC compared the surveyed code to MPC codes 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)* (work RVU = 0.98, 10 minutes intra-service time) and 52442 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)* (work RVU = 0.98, 15 minutes intra-service time), noting that the work values are identical and the times bracket the surveyed code, justifying the 13 minutes of intra-service time which falls in the middle of the two comparators. **The RUC recommends a work RVU of 0.98 for CPT code 15X22.**

**Practice Expense**
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made minor modifications to the supplies and equipment. In addition, the post-operative visits were revised to match the survey recommendations. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**New Technology**
The RUC recommends that CPT codes 15X19-15X22 be placed on the New Technology list to be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

**RUC Database Flag**
The RUC recommends that a "Do Not Use to Validate for Physician Work – Service times not representative" flag be placed in the RUC database for the family of CPT codes 15X19-15X22.

**Osteotomy - Spine (Tab 5)**
**Anthony DiGiorgo, MD (AANS), William Lavelle, MD (ISASS)**

In CY 2025 Rulemaking, 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 noted that these services were last reviewed in 1995, and all but CPT code 22216 did not have a description of work or vignettes describing the typical patient. CMS also noted that there may be the need for potential bundling of these services, such as CPT code 22210 and 22600 *Arthrodesis, posterior or posterolateral technique, 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 nominated this code family as potentially misvalued.

The RUC considered these services at the January 2025 RUC meeting. The specialty societies submitted a detailed letter on why they disagreed with the 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 and 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 for the January 2025 meeting and requested that the RUC refer this issue to the CPT Editorial Panel for revision. The specialties stated they would consult pediatric spine surgeons specializing in scoliosis surgery to submit a CPT Code Change Application (CCA).

At the September 2025 CPT Editorial Panel meeting, the existing codes and guidelines were revised to clarify that the codes include complete resection of the interspinous ligament and the entirety of the ligamentum flavum (ie, laminar and subarticular) to allow deformity correction through spinal column realignment. The osteotomy includes resection of the inferior portion of the lamina, the inferior facet of the cranial vertebra, the superior portion of the lamina, and the superior facet of the caudal vertebra. Following the revisions to the CPT guidelines and parentheticals for the code family, CPT codes 22210, 22212, 22214, and 22216 were surveyed for the January 2026 RUC meeting.

**Compelling Evidence**
The specialty societies presented compelling evidence based on a change in patient population and a change in technology compared to when these procedures were last reviewed under the Harvard Study over 30 years ago. The specialties explained that advances in segmental pedicle screw instrumentation, improved spinal implants, intraoperative fluoroscopy/CT, and increasingly navigation and neuromonitoring have allowed more complex and intense posterior osteotomies to be performed than in the early 1990s. This has resulted in a marked increase in adult spinal deformity surgery, with older, osteoporotic, and medically complex patients undergoing osteotomy to address fixed sagittal imbalance and disability rather than only classic ankylosing spondylitis. Expectations for function and quality of life have risen, and patient selection now places greater emphasis on global alignment parameters. **The RUC agrees that there is compelling evidence based on a change in the patient population and a change in technology.**

**22210** ***Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical***
The RUC reviewed the survey results from 32 neurosurgeons, orthopaedic surgeons, and spine surgeons and determined that the 25th percentile work RVU of 24.75 appropriately accounts for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 28 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 40 minutes immediate post-service time, 1-99231, 1-99232 and 1-99233 hospital visits, 1- 99239 discharge visit, 1-99214 and 2-99213 post-operative office visits. The RUC noted that this procedure is often performed with other spinal procedures, such as instrumentation and arthrodesis, and that any of the base surgical procedures reported together would be subject to surgical multiple procedure payment reduction (MPPR) policies. The specialties noted that the other procedures performed with osteotomy are often done at separate vertebral levels. The RUC also noted that this procedure is typically reported with add-on code 22216 for each additional vertebral segment. The RUC also observed that while the updated recommendation involves a large decrease in intra-service time relative to the Harvard study times, there has been an increase in total time. The RUC noted that, as reviewed during the compelling evidence discussion, the patient population has changed due to improvements in technology, which have resulted in an increase in the number of older, medically complex patients undergoing osteotomies. This change in patient population has increased the intensity of physician work compared to when this service was last valued over 30 years ago.

The specialties noted that cervical spine osteotomy procedures typically involve more pre-service positioning time relative to thoracic or lumbar spine osteotomies.The procedure involves a midline incision, removal of the spinous process, lamina, and facets of the index levels, along with parts of the lamina and facets of adjacent levels, and the ligamentum flavum between those levels. This creates a gap in the posterior elements, which can be closed symmetrically to restore balance on the sagittal plane or asymmetrically to correct a coronal deformity. This is often locked into place by additional maneuvers, which, for cervical cases, can involve breaking scrub and adjusting the head and the head holder, all while undergoing continuous neuromonitoring to ensure the integrity of the spinal cord and exiting nerve roots.

Post-operatively, the patient is carefully positioned back supine, typically has multiple post-operative inpatient days, which are spent managing pain, undergoing physical therapy, and managing neurovascular status in these frail patients. An additional inpatient day is needed due to the numerous clinical concerns that come with these significant operations on these typically older patients. Post-operative office visits include pain management, wound management, and typically review of post-discharge standing scoliosis imaging, and additional post-op visits are needed, due to the numerous clinical concerns that involve frailty, pulmonary issues, and pain.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU= 28.84, intra-service time= 150 minutes) and noted that the reference code involves more intra-service and slightly more total time and both services would have appropriate relativity to one another. The RUC also compared the surveyed code to CPT code 33880 *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* (work RVU= 26.33, intra-service time= 120 minutes) and noted that although both procedures involve the same amount of intra-service time, the reference code involves somewhat more total time. **The RUC recommends a work RVU of 24.75 for CPT code 22210.**

**22212** ***Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic***

The RUC reviewed the survey results from 34 neurosurgeons, orthopaedic surgeons and spine surgeons and determined a direct work RVU crosswalk to CPT code 37617 *Ligation, major artery (eg, post-traumatic, rupture); abdomen* (work RVU= 23.20, intra-service time= 120 minutes) appropriately accounts for the work required to perform this service, as supported by the physician work survey time data. The RUC noted that both services typically involve the same amount of intra-service time, and both procedures typically involve the same amount of physician work. The RUC recommends 40 minutes pre-service evaluation time, 18 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 34 minutes immediate post-service time, 1-99231, 2-99232 and 1-99233 hospital visits, 1- 99239 discharge visit, 1-99214 and 2-99213 post-operative office visits. The specialties noted that this procedure typically involves an additional inpatient day as the surgeon typically must address the clinical manifestations of altered chest wall dynamics. For instance, deformity correction in the thoracic spine often results in pulmonary complications. Patients often require a chest tube, for example, which typically accounts for this extra inpatient day.

The RUC noted that this procedure is often performed with other spinal procedures, such as instrumentation and arthrodesis, and that any of the base surgical procedures reported together would be subject to surgical multiple procedure payment reduction (MPPR) policies. The specialties noted that the other procedures performed with osteotomy are often done at separate levels. The RUC also noted that this procedure is typically reported with add-on code 22216 for each additional vertebral segment. The RUC also observed that while the updated recommendation involves a decrease in intra-service time relative to the Harvard study times, there has been a large increase in total time. The RUC noted that, as reviewed during the compelling evidence discussion, the patient population has changed due to improvements in technology, which have resulted in an increase in the number of older, medically complex patients undergoing osteotomies. This change in patient population has increased the intensity of physician work compared to when this service was last valued over 30 years ago.

The procedure involves a midline incision, removal of the spinous process, lamina, and facets of the index levels, along with parts of the lamina and facets of adjacent levels, and the ligamentum flavum between those levels. This creates a gap in the posterior elements, which can be closed symmetrically to restore balance on the sagittal plane, or asymmetrically to correct a coronal deformity. This is often locked into place by additional maneuvers while undergoing continuous neuromonitoring to ensure the integrity of the spinal cord and exiting nerve roots. Post-operatively, the patient is carefully positioned back supine, typically has multiple post-operative inpatient days, which are spent managing pain, undergoing physical therapy, and managing neurovascular status in these frail patients. An additional inpatient day is necessary due to the numerous clinical concerns that come with these significant operations on these typically older patients. Post-operative office visits include pain management, wound management, and typically review of post-discharge standing scoliosis imaging, and additional post-op visits are necessary, due to the numerous clinical concerns that involve frailty, pulmonary issues, and pain.

To support the recommended work RVU, the RUC compared the surveyed code to CPT 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= 23.12, intra-service time= 120 minutes) and noted that both services typically involve the same amount of intra-service time and the surveyed code involves somewhat more total time. **The RUC recommends a work RVU of 23.20 for CPT code 22212.**

**22214** ***Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar***
The RUC reviewed the survey results from 36 neurosurgeons, orthopaedic surgeons and spine surgeons and determined a direct work RVU crosswalk to CPT code 34707 *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 other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)* (work RVU= 21.72, intra-service time= 120 minutes) appropriately accounts for the work required to perform this service, as supported by the physician work survey time data. The RUC noted that both services typically involve the same amount of intra-service time and the same amount of physician work. The RUC recommends 40 minutes pre-service evaluation time, 18 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 1-99231, 1-99232 and 1-99233 hospital visits, 1- 99239 discharge visit, 1-99214 and 2-99213 post-operative office visits. The specialties noted that, compared to thoracic osteotomies, lumbar require additional protection of the nerve roots. For the thoracic spine, it is possible to sacrifice a nerve root with no neurologic deficit, as opposed to the lumbar spine, where that is not an option. The RUC recommended value would assign lumbar and thoracic spine osteotomies the same level of physician work intensity (IWPUT of 0.084).

The RUC noted that this procedure is often performed with other procedures, such as instrumentation and arthrodesis, and that any of the base surgical procedures reported together would be subject to surgical multiple procedure payment reduction (MPPR) policies. The specialties noted that the other procedures performed with osteotomy are often done at separate levels. The RUC also noted that this procedure is typically reported with add-on code 22216 for each additional vertebral segment. The RUC also observed that while the updated recommendation involves a decrease in intra-service time relative to the Harvard study times, there has been a large increase in total time. The RUC noted that, as reviewed during the compelling evidence discussion, the patient population has changed due to improvements in technology, which have resulted in an increase in the number of older, medically complex patients undergoing osteotomies. This change in patient population has increased the intensity of physician work compared to when this service was last valued over 30 years ago.

The procedure involves a midline incision, removal of the spinous process, lamina, and facets of the index levels, along with parts of the lamina and facets of adjacent levels, and the ligamentum flavum between those levels. This creates a gap in the posterior elements, which can be closed symmetrically to restore balance on the sagittal plane or asymmetrically to correct a coronal deformity. This is often locked into place by additional maneuvers while undergoing continuous neuromonitoring to ensure the integrity of the spinal cord and exiting nerve roots. Post-operatively, the patient is carefully positioned back supine, typically has multiple post-operative inpatient days, which are spent managing pain, undergoing physical therapy, and managing neurovascular status in these frail patients. An additional inpatient day is necessary due to the numerous clinical concerns that come with these significant operations on these typically older patients. Post-operative office visits include pain management, wound management, and typically review of post-discharge standing scoliosis imaging, and additional post-op visits are necessary, due to the numerous clinical concerns that involve frailty, pulmonary issues, and pain.

To support the recommended work RVU, the RUC compared the surveyed code to CPT 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= 23.12, intra-service time= 120 minutes) and noted that both services typically involve the same amount of intra-service time and similar total time, and the reference code is slightly more intense and complex. **The RUC recommends a work RVU of 21.72 for CPT code 22214.**

**22216** ***Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)***
The RUC reviewed the survey results from 34 neurosurgeons, orthopaedic surgeons and spine surgeons and determined a direct work RVU crosswalk to CPT code 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)* (work RVU= 3.00, intra-service time= 30 minutes) appropriately accounts for the work required to perform this service, , as supported by the physician work survey time data. The RUC noted that both services typically involve the same amount of intra-service time and physician work. The RUC recommends 30 minutes of intra-service and total time. The survey respondents and the 2024 Medicare claims data both indicated that this add-on code is most typically reported for each additional vertebral segment for lumbar osteotomies, as lumbar osteotomies have the highest volume overall. This add-on code is reported a median of 2 units according to the Medicare claims data as well. The RUC acknowledged the decrease in intra-service time compared to the 1995 RUC review.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 4.03, intra-service time= 40 minutes) and noted that the reference code involves more time and both procedures would be appropriately assigned a physician work intensity IWPUT of 0.10. The RUC also compared the surveyed code to CPT code 96548 *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU= 3.00, intra-service time= 30 minutes) and noted that both services would appropriately have the same time and value. **The RUC recommends a work RVU of 3.00 for CPT code 22216.**

**Practice Expense**
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. For the three base codes (CPT codes 22210, 22212 and 22214), the PE Subcommittee recommended the standard 090-day global facility clinical labor time of 60 minutes during the pre-service period and the standard times and direct inputs that coincide with the bundled post-operative discharge and office visits. For add-on code 22216, the PE Subcommittee recommended no direct practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

**Implantation Extra-articular Shock Absorber, Medial Knee (Tab 6)**
**William Creevy, MD (AAOS), Patrick Joyner, MD (AAOS)**

At the September 2025 CPT Meeting, the CPT Editorial Panel created a new Category I code to describe the implantation of a medial knee extra-articular shock absorber.

**27X05** ***Implantation of medial knee extra-articular shock absorber, including fluoroscopic guidance***
The RUC reviewed the survey results from 43 orthopaedic surgeons and spine surgeons and determined that a direct work RVU crosswalk to CPT code 15730 *Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)* (work RVU=13.16, intra-service time= 90 minutes) is appropriate and noted that both services typically involve the same amount of intra-service time and a similar amount of total time. The RUC recommends 33 minutes pre-service evaluation time, 12 minutes pre-service positioning time, 12 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 20 minutes immediate post-service time, 0.5x 99238 discharge visit, and 3-99213 post-operative office visits. The specialty noted that the pre-service positioning time includes placing the tourniquet and limb positioner. The survey respondents indicated that the patient is typically discharged on the same day that the procedure was performed.

The implant is approximately a 5-centimeter-long cylinder, and it articulates with two titanium base plates. These base plates are fixed to the femur and the tibia with three screws on either side. The procedure is performed through an open incision. The device is placed deep within the muscle on top of the medial collateral ligament, so it is placed outside of the knee joint. Measuring guides are used to ensure the correct positioning of the implant. The surgeon first places trial implants and checks the range of motion. If the range of motion is appropriate, then the final implants are placed and the range of motion of the final implants is assessed. This is typically an isolated procedure reported alone.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference code 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=14.63, intra-service time= 90 minutes) and noted that both services typically involve the same amount of intra-service time, whereas the reference code typically involves somewhat more total time. 90 percent of the survey respondents who selected the top key reference code indicated that the surveyed code is more intense and complex to perform. For additional support, the RUC also compared the surveyed code to 2nd key reference code 29888 *Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction* (work RVU= 13.94, intra-service time= 98 minutes) and noted that although the reference code has somewhat more intra-service and more total time, 90 percent of the survey respondents that selected this reference indicated the surveyed code is more intense and complex to perform. The RUC concurred that these three procedures would have appropriate relativity to one another. **The RUC recommends a work RVU of 13.16 for CPT code 27X05.**

**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 society.**

**New Technology**
CPT code 27X05 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.

**Osteochondral Acellular Scaffold Implantation, Knee (Tab 7)**
**William Creevy, MD (AAOS)**

In September 2025, the CPT Editorial Panel created a new Category I CPT code 27XX8, which describes open cartilage knee repair procedures with an acellular scaffold implant. The type of implant used in this procedure is a porous-coated, biodegradable scaffold consisting of inorganic coral exoskeleton. Current CPT coding distinguishes graft procedures using implants from sources including autograft (self), allograft (same species), and xenograft (living animal cells). Conversely, acellular implants, such as inorganic (non-living) aragonite (coral), consist of biocompatible and resorbable scaffolding, designed to support regeneration of the articular cartilage and its underlying subchondral bone. Using acellular implants avoids the need for cell harvesting and donor matching. By definition, not all xenografts are in the form of an acellular scaffold, as some can be used in the original cellular form. Based on the inorganic nature of these implants, the CPT Editorial Panel included the term "acellular scaffold" in the code descriptor for 27XX8, as it is a more comprehensive term and further defines the types of regenerative implants being used that are neither autologous nor allogenic. The CPT Editorial Panel did not request deletion for existing Category III code 0737T, which is currently being reported for this procedure, since it may appropriately describe procedures with this type of implant joints other than the knee. CPT code 27XX8 was surveyed for the January 2026 RUC meeting.

**27XX8** ***Acellular scaffold(s) (eg, aragonite) implant(s), for osteochondral lesion(s), knee, open***
The RUC reviewed survey results from 38 orthopaedic surgeons and recommends a work RVU of 9.53 based on a direct work RVU crosswalk to MPC CPT code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.53, 60 minutes intra-service time), which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 11 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 20 minutes of immediate post-service time, 0.5-99238 discharge visit and 3-99213 office visits.

The physician work involved with CPT code 27XX8 describes an open incision, whether on the medial or lateral aspect of the knee. The surgeon identifies the osteochondral defect, places an alignment guide over the defect, drills a wire into the bone, and then over that wire, drills out of the defect to normal surrounding articular cartilage. The surgeon will then place the acellular scaffold implant device into the precisely cut hole in the defect, positioned so that it is flush with the articular cartilage and carefully pushed into its final position using a tamper device that is 2 millimeters below the articular cartilage surface. The specialty society clarified that these steps would then be repeated for any additional defects treated but the service would only be reported once, regardless of the number of lesions, the size of the lesion, or the number of implants.

To support the recommended work RVU of 9.53, the RUC compared the surveyed code to CPT code 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)* (work RVU = 9.75, 60 minutes intra-service time). The RUC recognized that this reference service typically requires identical intra-service time as the 27XX8.

For additional support, the RUC referenced CPT code 49520 *Repair recurrent inguinal hernia, any age; reducible* (work RVU = 9.74, 60 minutes intra-service time), which typically requires identical intra-service service time as the surveyed code. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity across comparable services in the Medicare Physician Payment Schedule (MFS). **The RUC recommends a work RVU of 9.53 for CPT code 27XX8.**

**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 society.**

**New Technology**
CPT code 27XX8 will be placed on the New Technology/New Services list and will be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

**Insertion and Removal of Surgical Ventricular Assist Device (Tab 8)**
**Jordan Hoffman, MD (STS), Vigneshwar Kasirajan, MD (STS), James Levett, MD (STS), Brett Starr, MD (STS)**

At the September 2025 CPT Editorial Panel meeting, the Panel created three new category I CPT codes to describe the insertion and removal of a left heart ventricular assist device (VAD), specifically using an open arterial with conduit surgical approach.

VADs provide hemodynamic support to the right heart, left heart, or both. VADs may be used for temporary (days), short-term (days – weeks), or long-term (weeks – months) support. The smaller, temporary VADs are typically inserted via a percutaneous technique to support the left, right, or both ventricles. Short-term VADS are larger and provide support to the left ventricle and will typically require placement through a conduit placed on the axillary artery or aorta. The temporary and short-term VADs, also called micro axial devices, involve placement of the entire device in the right or left ventricle without any incisions into or within the heart. The longer-term or durable VADS are larger and typically require placement via a transthoracic (median sternotomy or thoracotomy) approach with cardiopulmonary bypass support and involve incisions and/or resections with direct anastomosis of the device to the ventricular wall and creation of a separate outflow graft from the VAD to the aorta. The location of the durable VADs may be intracorporeal (the pumping device is implanted in the chest) or extracorporeal (the pumping device is placed outside the body). Intracorporeal VADS typically provide left heart support, while extracorporeal VADS can provide single or bi-ventricular support. Currently, there are codes to report the percutaneous and durable VADS.

The two new VAD insertion codes under consideration (33X15 and 33X12) are for the mid-size short-term micro axial devices, where the entire pump is placed inside the heart to provide left ventricular support. The microaxial devices may be placed via an infraclavicular or supraclavicular exposure and cutdown on the axillary artery with conduit creation, or a transthoracic (median sternotomy/thoracotomy) exposure and cutdown of the aorta with creation of a conduit through which the device may be delivered. Radiological guidance is then used to advance the VAD through the artery, across the aortic valve, and into the apex of the left ventricle. The position is verified, and the microaxial device is secured. The removal code (33X13) involves weaning the patient from the device, exposure of the conduit, removal of the sutures holding the micro axial device in place and careful withdrawal of the device and all thrombus from the graft. The graft is stapled about 1-2 cm above the axillary or aortic artery, and the wound is closed in layers.

Similar to the durable VADs, these patients tend to stay in the hospital for longer periods of time, and they are followed postoperatively by a heart-team with a mix of intensivists, cardiologists and cardiothoracic surgeons providing the post-operative care. Due to this team care approach and multiple physicians providing the post-operative visits to the patients, the codes were valued as XXX-global procedures, which accounts for the pre-operative care on the day of the procedure, the procedure itself, and the immediate post-operative time through patient stabilization in the recovery room and communications with the patient and other professionals. As there is a limited number of

major surgical procedures with the XXX-global period (only two other code families reviewed in the past 20 years), the Research Subcommittee supported the specialty to use a mixed 000-day/XXX-global period reference service list as part of their survey process.

The specialty noted that the physician work for the placement and removal of these mid-sized temporary VADs via an open approach, and the creation of a conduit involves much more physician work than the placement of smaller, short-term VADs, which are typically placed via a percutaneous approach (codes 33990, 33991, 33995). The smallest short-term VADs, which are placed percutaneously, do not provide the same level of cardiac output support as the VADs described by codes 33X15, 33X12 and 33X13. Instead, these mid-sized temporary VADs are larger, with a size of about 21 French and cannot be inserted percutaneously. The surgeon places them through a cut-down into either the axillary artery or the aorta, using a conduit to then allow it to pass through the artery and the aortic valve and be positioned inside the ventricle. These are significantly more work in terms of the imaging, positioning, and manipulation than a percutaneous VAD. Conversely, open-approach durable VADs (codes 33975, 33976, 33979, 33977, 33978, 33980) require the most amount of work out of the three types of VADs.

**33X15** ***Insertion of left heart ventricular assist device, including radiological supervision and interpretation, open; axillary, subclavian or innominate artery exposure with creation of conduit by infraclavicular or supraclavicular incision, unilateral***
The RUC reviewed the survey results from 52 cardiac surgeons and determined a direct work RVU crosswalk to CPT code 33902 *Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral* (work RVU= 13.65, intra-service time= 90 minutes) appropriately accounts for the physician work required to perform this service. The RUC noted that both services typically involve the same amount of intra-service time and the surveyed code involves somewhat more total time. The RUC noted that, due to the lack of availability of XXX global reference codes, using 000-day global codes as a reference for XXX-global major surgery codes is warranted. The RUC recommends 68 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 45 minutes immediate post-service time. Of the three codes in this code family, this procedure has the second-highest intensity and represents the most common surgical approach for VAD insertion. The primary difference between family codes 33X12 and 33X15 is the approach (central aorta vs axillary).

Patients undergoing this procedure are typically complicated patients with heart failure and other comorbidities. For the pre-service evaluation work, similar to the durable VAD procedures (60 minutes pre-time), the physician performs a thorough review of the patient's history and medical records and all relevant laboratory, diagnostic tests and imaging, including echocardiogram, X-rays, relevant CT and coronary angiograms as well as imaging of the axillary artery. The physician performs a complete analysis of the anatomic constriction of the axillary artery, ascending aorta, and aortic valve into the left ventricle and evaluates these for thrombus or damage to ensure safe insertion of the device. The physician also evaluates the aortic and mitral valve stenosis, regurgitation, and functions to ensure safe implantation and to inform post-placement function and cardiac impact. For the pre-service positioning work, 15 minutes is typical to account for the additional time required for padding and positioning, consistent with other cardiac procedures. For the immediate post-service work, additional time is required to account for the time spent obtaining hemodynamic stability, optimizing the LVAD settings, which require frequent changes in response to volume status changes and the need for alpha agents to maintain blood pressure, and the effect of the VAD coagulation management. Extended observation in the operating room is required to ensure the VAD-left heart-volume relationship is stable enough for the diminished monitoring available during transport.

As part of the discussion, the RUC noted that since these services are assigned the XXX global period, a same-day E/M service could separately be reported. The RUC noted that, to avoid potential time overlap in the survey estimates with a separately reported service, the survey instrument prominently instructed survey respondents, "Do not include time for work related to another service, procedure, revaluation and management code that is separately reportable." Also, the survey defined the immediate post-service time as "Post-operative care on day of the procedure, includes "non-skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders)."

To support the recommended work RVU, the RUC compared the surveyed code to CPT codes 33988 *Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS* (work RVU= 14.63, intra-service time= 90 minutes) and noted that both services involve the same amount of intra-service time, whereas the reference code involves somewhat more total time. For additional support, the RUC also compared the surveyed code to CPT code 93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* (work RVU= 13.41, intra-service time= 90 minutes) and noted that both services typically involve the same amount of intra-service time, whereas the surveyed code typically involves more total time. The RUC noted that reference codes 33988 and 93583 appropriately bracket the surveyed code, and the three services would have appropriate relativity. **The RUC recommends a work RVU of 13.65 for CPT code 33X15.**

**33X12** ***Insertion of left heart ventricular assist device, including radiological supervision and interpretation, open; aorta exposure with creation of conduit by transthoracic (eg, median sternotomy, thoracotomy) incision***

The RUC reviewed the survey results from 50 cardiac surgeons and determined a direct work RVU crosswalk to CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU= 17.52, intra-service time= 120 minutes) would appropriately account for the physician work required to perform this service. The RUC noted that both services typically involve the same amount of intra-service time, whereas the surveyed code involves much more total time. The RUC noted that, due to the lack of availability of XXX global reference codes, using 000-day global codes as a reference for XXX-global major surgery codes is warranted. The RUC recommends 71 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 60 minutes immediate post-service time. Of the three codes in this code family, CPT code 33X12 has the highest level of physician work intensity and complexity. CPT code 33X12 would only be used in patients where 33X15 is contraindicated or there is another patient-specific consideration necessitating insertion via this approach. The primary difference between family codes 33X12 and 33X15 is the approach (central aorta vs axillary). For example, in CPT code 33X12 the pump insertion under general anesthesia supported by fluoroscopic and transesophageal imaging traversing the aortic valve pumping blood from the left ventricle to the aorta, thus unloading the left ventricle, is similar.

Patients undergoing this procedure are typically complicated patients with heart failure and other comorbidities. For the pre-service evaluation work, similar to the durable VAD procedures (60 minutes pre-time), the physician performs a thorough review of the patient's history and medical records and all relevant laboratory, diagnostic tests and imaging including echocardiogram, X-rays, relevant CT and coronary angiograms, as well as imaging of the axillary artery. The physician performs a complete analysis of the anatomic constriction of the axillary artery, ascending aorta, and aortic valve, into the left ventricle and evaluates these for thrombus or damage to ensure safe insertion of the device. The physician also evaluates the aortic and mitral valve stenosis, regurgitation, and functions to ensure safe implantation and to inform post-placement function and cardiac impact. For

the pre-service positioning work, 15 minutes is typical to account for the additional time required for padding and positioning, consistent with other cardiac procedures. For the immediate post-service work, similar to 33X15, additional time is required for the time spent obtaining hemodynamic stability, optimizing the LVAD settings, which require frequent changes in response to volume status changes and the need for alpha agents to maintain blood pressure, and the effect of the VAD coagulation management. Extended observation in the operating room is required to ensure the VAD-left heart-volume relationship is stable enough for the diminished monitoring available during transport. The additional 15 minutes of immediate post-service time over code 33X15 is due to the additional time required in monitoring and stabilization of the patient, which is longer due to the central approach and the increased complexity of the patient that required the alternative approach.

As part of the discussion, the RUC noted that since these services are assigned the XXX global period, a same-day E/M service could separately be reported. The RUC noted that, to avoid potential time overlap in the survey estimates with a separately reported service, the survey instrument prominently instructed survey respondents, "Do not include time for work related to another service, procedure, revaluation and management code that is separately reportable." Also, the survey defined the immediate post-service time as "Post-operative care on day of the procedure, includes 'non-skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders)."

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 33903 *Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral* (work RVU= 16.09, intra-service time= 120 minutes) and noted that although both services involve the same amount of intra-service time, the surveyed code involves much more total time, justifying its recommended value relative to the reference code. The RUC also compared the surveyed code to CPT code 33894 *Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches* (work RVU= 17.81, intra-service time= 134) and noted that although the reference code involves somewhat more intra-service time, both codes have similar total times and both services would have appropriate relativity to each other at the recommended value. **The RUC recommends a work RVU of 17.52 for CPT code 33X12.**

**33X13** ***Removal of left heart ventricular assist device with resection and stapling of graft conduit and skin closure (eg, infraclavicular, supraclavicular)***
The RUC reviewed the survey results from 52 cardiac surgeons and determined a direct work RVU crosswalk to CPT code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU= 6.58, intra-service time- 45 minutes) would appropriately account for the physician work required to perform this service. The RUC noted that although the reference service typically involves 5 minutes more intra-service time, it involves much less total time, and both services typically involve the same overall amount of physician work. The RUC noted that, due to the lack of availability of XXX global reference codes, using 000-day global codes as a reference for XXX-global major surgery codes is warranted. The RUC recommends 50 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 40 minutes intra-service time, 30 minutes immediate post-service time. Of the three codes in this code family, CPT code 33X13 has the lowest level of physician work intensity and complexity. This removal code (33X13) involves weaning and the patient from LVAD support and ensuring sufficient left ventricular recovery, reopening of the surgical site (axillary or aortic) dissection of the graft from surrounding scar tissue, withdrawal of the micro axial device under direct control to prevent embolic events, establishment of vascular control, transection, stapling and closure of the graft conduit, arterial and wound closure.

The typical patient is in the ICU post-placement of a VAD through a conduit attached to the axillary artery or the ascending aorta and cardiogenic shock has recently been resolved.

As part of the discussion, the RUC noted that since these services are assigned the XXX global period, a same-day E/M service could separately be reported. The RUC noted that, to avoid potential time overlap in the survey estimates with a separately reported service, the survey instrument prominently instructed survey respondents, "Do not include time for work related to another service, procedure, revaluation and management code that is separately reportable." Also, the survey defined the immediate post-service time as "Post-operative care on day of the procedure, includes 'non-skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders)."

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 49014 *Re-exploration of pelvic wound with removal of preperitoneal pelvic packing, including repacking, when performed* (work RVU= 6.56, intra-service time= 45 minutes) and noted that although the reference code typically involves 5 additional minutes of intra-service time, the surveyed code typically involves more total time. The RUC also compared the surveyed code to CPT code 31601 *Tracheostomy, planned (separate procedure); younger than 2 years* (work RVU= 7.80, intra-service time= 45 minutes) and noted that although the reference code typically involves 5 additional minutes of intra-service time and is a slightly more intense service to perform, the surveyed code typically involves more total time. The RUC concurred that these three services would have appropriate relativity to each other. **The RUC recommends a work RVU of 6.58 for CPT code 33X13.**

**Practice Expense**
The PE Subcommittee reviewed the direct practice expense inputs and modified the pre-service clinical staff time for CPT codes 33X15 and 33X12. The PE Subcommittee agreed that even though the patients for the two insertion codes are in the ICU with cardiogenic shock, the practice's clinical staff would still typically be doing some pre-service work for these patients. Rather than the standard 60 minute pre-service clinical staff time package for major surgical procedures, the PE Subcommittee determined that assigning the Emergent surgical procedure clinical staff standard of 20 minutes was appropriate. The PE subcommittee removed all clinical staff time for the removal code 33X13**. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**New Technology**
CPT codes 33X15, 33X12 and 33X13 will be placed on the New Technology/New Services list and will be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

**<u>Transcatheter Tricuspid Valve Replacement / Edge-to-Edge Repair (Tab 9)</u>**
**Afnan Raouf Tariq, MD (SCAI), Edward Tuohy, MD (ACC), Richard Wright, MD (ACC)**

In September 2025, the CPT Editorial Panel approved the addition of a code and related guidelines to report percutaneous transcatheter tricuspid valve replacement (TTVR) with prosthetic valve, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography; addition of two codes and guidelines to report percutaneous transcatheter tricuspid edge-to-edge repair (T-TEER); and deletion of the existing Category III codes [0569T, 0570T].

When surveying this new family of codes for TTVR and T-TEER for the January 2026 RUC meeting, the specialty societies requested Research Subcommittee approval to use the 000-day global with visit survey template for the 000-day codes. The societies noted that they last used this template for their 2018 survey for transcatheter aortic valve replacement (TAVR 33361-33366). The societies noted that the TTVR codes are similar to the TAVR codes, which include a same-day post-operative visit. The Category III codes on which these new codes are based (0646T, 0569T) have both been performed as inpatient services more than 95% of the time. The Research Subcommittee approved the 000-day global visit survey template for the new code family.

To further justify a post-operative visit for CPT codes 33X50 and 33X51, the RUC referenced CPT code 61737 *Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)* (work RVU = 22.10, 235 minutes intra-service time) and noted the precedent set when this 000-day global code was valued in January 2021 with one 99233 post-op visit. At that time, the RUC noted that the LITT codes "have 000-day global periods which typically do not allow for an E/M visit on the same day as the procedure. However, unlike code 61736, CPT code 61737 typically involves a full 2-midnight admission, as reflected by the survey respondents, which justifies the same-day E/M visit." The RUC confirmed that CPT codes 33X50 and 33X51 cross the two-night threshold and that, while not typical for 000-day global codes, CMS has allowed for a post-operative visit in these instances. The RUC further noted that the post-op visit is necessary given the extremely complex and high-risk nature of the patient population, often end-stage heart failure, with critical needs following the major surgical procedure. Per the survey respondents, 100% indicated that they perform the procedure as inpatient and that the patient would remain in the hospital overnight. Further, for codes 33X50 and 33X51, 82% and 68% of respondents, respectively, indicated the patient would remain in the hospital overnight and more than 24 hours. The majority of respondents indicated that a high-level subsequent hospital inpatient observation service was typically conducted on these patients. **Based on this information, the RUC recommends a 99233 subsequent hospital inpatient visit for CPT codes 33X50 and 33X51 as supported by the survey.**

**33X50** ***Transcatheter tricuspid valve replacement (TTVR) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed***
The RUC reviewed the survey results from 49 interventional cardiologists and determined that the survey 25$^{th}$ percentile work RVU of 24.38 appropriately accounts for the physician work involved in this service. CPT code 33X50 will be used to report the transcatheter tricuspid valve implantation/replacement service. The RUC recommends 50 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 17 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time and 1-99233 subsequent hospital inpatient visit as supported by the survey. CPT code 33X50 includes the physician work of percutaneous vascular access, placing the access sheath, right heart catheterization, advancing the valve replacement device system into position, repositioning the valve delivery device as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210, 33211), and access site closure by any method, when performed. CPT code 33X50 also includes intraprocedural angiography, radiological supervision and interpretation, intraprocedural roadmapping (eg, contrast injections, fluoroscopy) to guide TTVR or T-TEER (eg, guiding device placement and documenting completion of the intervention), and completion angiography. It also includes right atrial and/or right ventricular angiography (eg, to assess tricuspid regurgitation for guidance of TTVR or T-TEER).

Pre-service time package 4 was selected for difficult patient/difficult procedure in the facility setting, with an increase of 10 minutes over the package for a total evaluation time of 50 minutes, as supported by the survey. Operators execute an extensive review of the patient's laboratory and

diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram, and primary CT and angiographic images from prior studies. The physician determines appropriate antiplatelet and other pharmacologic therapy. The physician must also coordinate with other care team members prior to the procedure. Post-service time package 9B was selected for complex anesthesia procedures with time removed to comply with the survey.

The RUC compared CPT code 33X50 to the top key reference service 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 24.38, 180 minutes intra-service time) and noted that the transcatheter pulmonary valve implantation is a comparable service that involves a similar amount of physician work. 83% of survey respondents who selected the top key reference service indicated that the surveyed code is somewhat more or much more intense/complex than the key reference service, with 54% specifically noting it is much more intense/complex. Given that the work value for the key reference service matches the survey 25$^{th}$ percentile value for the surveyed code, the RUC concurs that 24.38 work RVUs is the appropriate value for this service. **The RUC recommends a work RVU of 24.38 for CPT code 33X50.**

**33X51** ***Transcatheter tricuspid valve edge-to-edge repair (T-TEER), percutaneous approach; initial clip***

The RUC reviewed the survey results from 47 interventional cardiologists and determined that the survey 25$^{th}$ percentile work RVU of 23.92 appropriately accounts for the physician work involved in this service. CPT code 33X51 will be used to report the transcatheter tricuspid valve edge-to-edge repair, initial clip. The RUC recommends 50 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 20 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time and 1-99233 subsequent hospital inpatient visit as supported by the survey. CPT code 33X51 includes the physician work of percutaneous vascular access, placing the access sheath, right heart catheterization, advancing the repair device system into position, repositioning the clip as needed, deploying the clip, and access site closure by any method, when performed. Code 33X51 may only be reported once per session. CPT code 33X51 also includes intraprocedural angiography, radiological supervision and interpretation, intraprocedural roadmapping (eg, contrast injections, fluoroscopy) to guide TTVR or T-TEER (eg, guiding device placement and documenting completion of the intervention), and completion angiography. It also includes right atrial and/or right ventricular angiography (eg, to assess tricuspid regurgitation for guidance of TTVR or T-TEER).

Pre-service time package 4 was selected for difficult patient/difficult procedure in the facility setting, with an increase of 10 minutes over the package for a total evaluation time of 50 minutes, as supported by the survey. Operators execute an extensive review of the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physician determines appropriate antiplatelet and other pharmacologic therapy. The physician must also coordinate with other care team members prior to the procedure. Post-service time package 9B was selected for complex anesthesia procedures with time removed to comply with the survey.

The RUC compared CPT code 33X51 to the key reference service codes 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 24.38, 180 minutes intra-service time) and 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU = 21.16, 135 minutes intra-service time) and noted that the physician work of the surveyed code is

appropriately bracketed between the two key reference services while the intensity of the surveyed code is more than either reference service. Given that the survey 25th percentile value falls between the key reference service values and the vast majority of survey respondents indicated that the surveyed code was somewhat or much more intense/complex, the RUC concurs that 23.92 work RVUs is the appropriate value for this service.

For additional support, the RUC referenced CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU = 23.78, 180 minutes intra-service time), noting the similar amount of physician work involved in both procedures. The RUC also referenced CPT code 49618 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated* (work RVU = 22.10, 180 minutes intra-service time) which has more intra-service time and is less intense than the surveyed code and is therefore appropriately valued less. The RUC concluded that CPT code 33X51 should be valued at the 25th percentile work RVU with a post-operative inpatient visit as supported by the survey. **The RUC recommends a work RVU of 23.92 for CPT code 33X51.**

**33X52** ***Transcatheter tricuspid valve edge-to-edge repair (T-TEER), percutaneous approach; each additional clip during same session***

The RUC reviewed the survey results from 47 interventional cardiologists and determined that the survey 25th percentile work RVU of 8.00 appropriately accounts for the physician work involved in this add-on service. CPT code 33X52 will be used to report the transcatheter tricuspid valve edge-to-edge repair, each additional clip during the same session. The RUC recommends 50 minutes of intra-service time as supported by the survey. CPT 33X52 is an add-on code reported in conjunction with 33X51 for each additional clip placed. CPT Code 33X52 includes the physician work of percutaneous vascular access, placing the access sheath, right heart catheterization, advancing the repair device system into position, repositioning the clip as needed, deploying the clip, and access site closure by any method, when performed. CPT code 33X52 also includes intraprocedural angiography, radiological supervision and interpretation, intraprocedural roadmapping (eg, contrast injections, fluoroscopy) to guide TTVR or T-TEER (eg, guiding device placement and documenting completion of the intervention), and completion angiography. It also includes right atrial and/or right ventricular angiography (eg, to assess tricuspid regurgitation for guidance of TTVR or T-TEER).

The RUC compared CPT code 33X52 to the top key reference service 33257 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)* (work RVU = 9.39, 30 minutes intra-service time) and noted that the key reference service requires less intra-service time and is much more intense/complex than the surveyed code and is therefore appropriately valued higher.

The RUC compared the surveyed code to the second key reference service 33225 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)* (work RVU = 8.12, 120 minutes intra-service time) and noted that the key reference service requires much more intra-service time than the surveyed code yet the surveyed code is much more intense, supporting the similar work values.

For additional support, the RUC compared the surveyed code to CPT code 33518 *Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)* (work RVU = 7.73, 50 minutes intra-service time) which requires the same intra-service time; however, the surveyed code is more intense, justifying a higher work value.

The RUC also referenced MPC code 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 = 7.76, 65 minutes intra-service time) and noted that the comparator code has more intra-service time and is less intense than the surveyed code and is therefore appropriately valued less.

The RUC considered relativity within the code family, ensuring that the intensity of the add-on code does not exceed that of the recommended value for its base code 33X51. The RUC also considered relativity overall in concluding that CPT code 33X52 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 8.00 for CPT code 33X52.**

**Practice Expense**
**The RUC recommends no direct practice expense inputs for CPT codes 33X50-33X52 as they are facility-only services.**

**New Technology**
CPT codes 33X50-33X52 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Microvascular Bypass, Lymphatic Vessels (Tab 10)**
**Phillip Brazio, MD (ASPS), Jeff Kozlow, MD (ASPS), Tom Willson, MD (ASPS)**

Microvascular bypass of lymphatic vessels describes the physician work involved with identifying, preparing, and anastomosing lymphatic vessels to a local or regional adjacent vein. In September 2025, the CPT Editorial Panel created two new Category I codes to describe this microsurgical procedure based on substantial clinical utilization, well-established surgical technique, and increasing evidence demonstrating efficacy in both therapeutic and preventative applications of lymphedema care. Before the creation of this code family, the CPT code set did not include codes dedicated to describing this specific physician work, instead relying on generalized vascular repair codes or unlisted codes for reporting, neither of which accurately characterizes the specialized super-microsurgical techniques, intraoperative imaging requirements, and overall work intensity involved with super-microsurgical lymphatic procedures. This newly created Category I CPT code family describes two services: CPT code 38X03 is the base code for the initial anastomosis, and CPT code 38X04 is the add-on code for each additional anastomosis. Category III code 1019T was created at the May 2025 CPT Editorial Panel meeting for CPT 2026 but will be deleted for CPT 2027 due to the creation of the two new Category I codes. CPT codes 38X03 and 38X04 were surveyed for the January 2026 RUC meeting.

**38X03** ***Microvascular anastomosis between a single vein opening and any number of lymphatic vessels, per limb; initial anastomosis***
The RUC reviewed survey results from 92 plastic surgeons and recommends the survey median work RVU of 16.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 10 minutes of pre-service

positioning time, 10 minutes of pre-service scrub/dress/wait time, 113 minutes of intra-service time, 23 minutes of immediate post-service time, 0.5-99238 discharge visit and 3-99213 office visits.

The physician work involved with CPT code 38X03 describes the initial microsurgical anastomosis between a lymphatic vessel and a vein. The typical patient for this procedure has undergone previous lymph node dissections and has developed subsequent lymphedema of the arm or extremity that is recalcitrant to conservative therapies. This is tedious and highly technical microsurgery, where the majority of time is spent under an operating microscope at 10 to 30 magnification and involves lymphatics that are typically smaller than 0.8 millimeters. This service is intended to identify open lymphatics for the remainder of the extremity and micro-surgically anastomose them to an adjacent venule to reroute the lymphatic drainage that is getting obstructed into the venous system to aid decongestion. The surgeon will also use multiple lymphophilic dyes and concurrent imaging that are done intraoperatively in order to identify the potential targeted lymphatic vessels for transfer and the initial supermicrosurgical anastomosis. The specialty society clarified that approximately 75 percent of the intra-service time is dedicated to performing the anastomosis, while the remaining 25 percent of intra-service time involves the intradermal injection of lymphophilic dye in the affected extremity and other necessary imaging for mapping current lymphatic drainage and obstructions.

The specialty society selected pre-service time package *3A-FAC Straightforward Patient/Difficult Procedure* and post-service time package *9A General Anes or Complex Reg Blk/Strghtforw Proc*, which the RUC confirmed is appropriate and consistent with RUC standards given the need for anesthesia care in the pre-service time period and the overall lower complexity of the clinical circumstance in the post-service time period.
To support the recommended work RVU of 16.00, the RUC compared the surveyed code to MPC codes 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.31 and 103 minutes intra-service time). The RUC recognized that the surveyed code requires more intra-service time than the reference MPC code, but notes that 37215 is more intense/complex to perform and is appropriately valued with a higher work RVU. **The RUC recommends a work RVU of 16.00 for CPT code 38X03.**

**38X04** ***Microvascular anastomosis between a single vein opening and any number of lymphatic vessels, per limb; initial anastomosis; each additional anastomosis (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 93 plastic surgeons and recommends the survey 25$^{th}$ percentile work RVU of 6.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 60 minutes of intra-service time. The specialty society noted that this add-on code will be used in cases where an additional anastomosis is required, typically involving one to four anastomoses as necessary.

The specialty society clarified that compared to its base code, CPT code 38X04 is a slightly more intense/complex procedure to perform. Unlike CPT code 38X03, this add-on service does not involve any of the work involving intradermal injection of lymphophilic dye or other imaging for mapping lymphatics that is required prior to and during the initial anastomosis. Instead, nearly all of the intra-service time is spent micro-surgically operating under high-powered magnification on a different lymphatic vessel in the same extremity that has been separately identified.

To support the recommended work RVU of 6.00, the RUC compared the surveyed code to CPT code 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)* (work RVU = 6.00 and 60 minutes intra-service time) and recognized that this reference service typically requires identical intra-service time, total time, and overall intensity/complexity to perform, thus supporting that both services have the same work RVU.

For additional support, the RUC referenced MPC codes 34715 *Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 5.85 and 60 minutes intra-service time) and 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 = 6.34 and 60 minutes intra-service time). The RUC recognized that both MPC reference codes typically require identical intra-service and total time, as well as bracket the surveyed code in terms of intensity/complexity. Overall, the RUC work RVU recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity across comparable services in the Medicare Physician Payment Schedule (MFS). **The RUC recommends a work RVU of 6.00 for CPT code 38X04.**

**Practice Expense**
The PE Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee confirmed that the addition of equipment item ED005 *camera, digital system, 12 megapixel (medical grade)* was appropriate, given the series of photographs taken. The specialty society clarified that these photographs are taken after surgery for complex reconstruction patients (such as those with lymphedema) to more closely measure and monitor the actual differences in the arms or legs that are being operated on. Unlike taking a picture of a wound for documentation in a patient's chart, these standardized photographs are staged accordingly and in a specific setup, comparable to breast reconstruction codes that require the same amount of clinical time. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

**New Technology**
CPT codes 38X03 and 38X04 will be placed on the New Technology/New Services list and will be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

**Diaphragmatic Hernia Repair (Tab 11)**
**Christopher Childers, MD (ACS), Vigneshwar Kasirajan, MD (STS), James Levett, MD (STS), Daniel McCarthy, MD (STS), Dmitry Nepomnayshy, MD (SAGES), Ketan Sheth, MD (SAGES)**
**Facilitation Committee #1**

At the September 2025 CPT Editorial Panel Meeting, two existing CPT codes were revised, and nine new Category I codes were created to describe the breadth of surgical interventions for repairing non-neonatal diaphragmatic hernias. Upon review of the literature and the submitted code change application, the CPT Editorial Panel approved the following:

1. Revised 2 codes to specify diaphragmatic repair via laparotomy (39540, 39541)

2. Created 1 code for reporting repair of non-traumatic diaphragmatic hernias via laparotomy (39XX3)
3. Created 2 codes for reporting repair of chronic traumatic and non-traumatic hernias via thoracotomy (39XX4, 39XX5)
4. Created 3 codes for reporting repair of acute, chronic traumatic, and non-traumatic diaphragmatic hernias via laparoscopy (39XX7-X9)
5. Created 2 codes for reporting repair of chronic traumatic and non-traumatic diaphragmatic hernias via thoracoscopy (39X11, 39X12)
6. Created 1 add-on code for reporting the implantation of mesh or another prosthesis with open, laparoscopic, and thoracoscopic diaphragmatic hernia repair (39X13)

**Compelling Evidence**
The specialty societies presented compelling evidence based on a change in patient population related to a change in technology compared to when these procedures were last reviewed under the Harvard Study over 30 years ago. Trauma care has evolved and improved significantly since the values of CPT codes 39540 and 39541 were established. Improvements in injury prevention and safety standards have reduced the proportion of trauma patients requiring operative intervention, while advances in trauma systems and high-quality imaging have shifted many patients toward nonoperative or minimally invasive surgical management. Laparoscopy (and robotic surgery) was in its early stages and would not have been typical physician practice for complex procedures such as diaphragmatic hernia repair when these codes were originally established. In current practice, minimally invasive surgical approaches are commonly employed and require advanced technical expertise. Additionally, numerous suture materials and prosthetic mesh options have been introduced since the 1980s, and contemporary understanding of durable repair techniques, including preperitoneal approaches, has further altered operative complexity and decision-making.

As a result, patients necessitating open surgical laparotomy for repairing either an acute or chronic diaphragmatic hernia resulting from trauma are now more complex, having higher injury severity scores, larger or complex diaphragmatic defects, or prior abdominal surgery. Patients with less complex clinical scenarios may now undergo a laparoscopic repair, reflected in the new CPT codes developed in this code family, causing an overall shift in the typical patient who undergoes the procedures represented in CPT codes 39540 and 39541. **The RUC agreed there is compelling evidence that there has been a change in patient population due to changes in technology used to perform these services.**

**Code Family**
Non-neonatal acquired diaphragmatic hernias can be acute or chronic. Acute diaphragmatic hernias are caused by a traumatic incident that creates a defect in the diaphragm as a result of a sudden increase in intra-abdominal pressure (eg, blunt trauma in a motor vehicle accident) or a penetrating injury (eg, knife wound). This will cause a tear in the diaphragm that may be associated with the migration of abdominal contents from the abdomen to the thoracic cavity. A chronic diaphragmatic hernia occurs when the trauma causes a tiny rupture of the diaphragm that is missed at the time of injury but is discovered when the patient presents delayed symptoms and complications later in life.

Non-neonatal congenital diaphragmatic hernias are often referred to as nontraumatic diaphragmatic hernias. The Morgagni hernia is an anterior, retrosternal, or parasternal defect of the diaphragm that develops from failure of the complete migration of muscle fibers to cover the triangular space located between the sternum and the bilateral costal margins (foramina of Morgagni). It can remain asymptomatic for many years, and therefore, its diagnosis is often incidental. The specialty societies noted in the summary that this is diagnosed at an average of 42 years. Repair is advised in patients who can tolerate surgery for both symptomatic and asymptomatic Morgagni hernias. Another type of

non-neonatal congenital diaphragmatic hernia is the Bochdalek hernia, which results from posterolateral defects in the diaphragm. These too may be asymptomatic and incidentally found but also may be symptomatic based on the volume of herniated contents. Bowel obstruction and strangulation are risks for both of these hernia types. Surgery is the mainstay of treatment.

Determining a surgical approach for the different acquired and congenital hernias (laparotomy, thoracotomy, laparoscopy, thoracoscopy) is largely dependent on patient presentation. For example, a thoracotomy or thoracoscopy may provide better access to the diaphragmatic defect, particularly for posterior hernias or where there is no damage to abdominal organs in the non-acute setting. Likewise, a laparotomy or laparoscopy is more often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs, especially with respect to acute traumatic diaphragmatic hernias. The specialty societies noted that the choice of surgical approach may depend not only on the specific clinical situation, including the size and location of the hernia, but also on the surgeon's experience and the patient's overall health and presentation.

**39540** ***Repair, diaphragmatic hernia (other than neonatal), traumatic; acute***
The RUC reviewed survey results from 41 trauma surgeons and recommends the survey median work RVU of 24.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99233 hospital visit, 2-99232 hospital visits, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes open surgical laparotomy, which repairs an acute traumatic hernia in the patient’s diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and laparotomy is often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs. This is especially true with acute diaphragmatic hernias, which are typically caused by a traumatic incident that creates a defect in the diaphragm as a result of a sudden increase in intra-abdominal pressure (e.g., blunt trauma in a motor vehicle accident). Typically, the diaphragm is blown out, and the large tear may be associated with the migration of abdominal contents from the abdomen to the thoracic cavity. These patients will not be in stable condition and may not be able to undergo extensive imaging, such as a CT scan; instead, the surgeon may utilize a chest x-ray before rushing the patient to the operating room to try to determine whether an occult injury in the abdomen and/or chest has been sustained. As part of the pre-service work for this service, the surgeon will need to review the length and type of anesthesia with the anesthesiologist and coordinate with other surgical specialties that may be involved to discuss the sequence, timing, and scope of all necessary procedures.

This open laparotomy is not commonly performed, and the primary goal is to reduce viscera contents and fix/close the diaphragmatic defect. These high-acuity patients must not be kept in the operating room any longer than necessary, since they are at great risk of becoming coagulopathic. The trauma surgeon will then perform a stem-to-stern laparotomy. These patients will have massive amounts of blood in their abdomen and will likely be receiving blood transfusions during the entire procedure. After the chest tube has been placed and the diaphragm is repaired, the patient is ready to go to the intensive care unit (ICU) intubated, due to the concern that they could have blossoming pulmonary contusions from the blunt traumatic injury. The surgeon is active in this patient’s post-operative recovery, which includes diligent monitoring of anesthesia, respiratory therapy, management of ventilator settings and the chest tube, as well as the laparotomic incision. Over the next few days, the patient will get extubated, have their chest tube removed, and will gradually have their diet advanced.

During this time, the surgeon will continue to monitor the patient's status, which is essential in contemporary practice to track the progress of high-acuity surgical patients such as this.

The specialty societies noted that 3 minutes of pre-service positioning time is appropriate for this service and typical for this type of open surgical procedure. Other laparoscopic and thoracoscopic 090-day global period services in this code family require 15 minutes of pre-service positioning time, but the RUC recognized that 12 fewer minutes of pre-service positioning time is consistent with the other open surgical procedures in this code family, including chronic traumatic laparotomy (CPT code 39541) and congenital nontraumatic laparotomy (CPT code 39XX3).

The specialty societies clarified that 120 minutes of intra-service time is appropriate for this service, given that sewing the diaphragmatic defect during open surgery takes less time and is less technically challenging to perform than during a laparoscopic or thoracoscopic surgical approach. For further recovery and continued pain management, the patient will typically stay in the hospital for 4 days post-operatively, which includes time to heal from the insertion of the chest tube. Based on the high-acuity status of the patient, the specialty societies noted that a 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50, 40 minutes of intra-service time) critical care visit would typically be reported separately and in addition to CPT code 39540 following the surgery. The RUC agreed this is appropriate and in conjunction with CMS guidelines related to using Modifier-24 to report a 99291 critical care for continued post-operative care for these especially high-acuity trauma patients.

To support the work RVU of 24.00, the RUC compared the surveyed code to CPT 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 = 23.40, 120 minutes intra-service time), which typically has identical intra-service time, similar total time and comparable relative intensity/complexity as the surveyed code.

For additional support, the RUC compared the surveyed code to MPC codes 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 20.63, 120 minutes intra-service time) and 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 28.84, 150 minutes intra-service time). The RUC recognized that while the surveyed code has identical intra-service time as MPC code 35301, but CPT code 39540 is a significantly more intense/complex procedure for the physician to perform. Likewise, MPC code 34705 requires more intra-service time, total time, and is more intense/complex to perform than the surveyed code. Together, these reference services bracket the median survey work RVU and maintain relativity within this code family and across the Medicare Physician Payment Schedule (MFS). **The RUC recommends a work RVU of 24.00 for CPT code 39540.**

**39541** ***Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic***
The RUC reviewed survey results from 33 trauma surgeons and recommends the 25th survey percentile work RVU of 26.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes an open surgical laparotomy, which repairs a chronic traumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and laparotomy is often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs. A chronic traumatic hernia occurs when an acute trauma causes a tiny rupture of the diaphragm that is missed at the time of injury. Patients might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or gastrointestinal (GI) symptoms. Similar to paraesophageal hernia repairs, chronic traumatic diaphragmatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation. In some cases, the colon, spleen, pancreas, and/or stomach have all herniated up into the patient's chest.

For a variety of reasons, the patient elects an open surgical operation, which might simply be due to the size of the defect, making laparoscopic sewing too challenging or not tenable. Repair typically involves a larger incision and more extensive dissection in scarred tissues. In particular, the dense adhesions between herniated viscera (stomach, omentum, small bowel, colon, spleen, pancreas) and thoracic structures requires extensive adhesiolysis, which impacts operative complexity, blood loss, technical difficulty, and post-operative recovery. The larger defect often requires complex reconstruction with nonabsorbable sutures and/or prosthetic reinforcement, with close proximity to the lung and pericardium. Large chronic traumatic hernias may present with compromised lung function and displaced mediastinum, and reduction plus repair can cause abrupt shifts in intrathoracic and intra-abdominal pressures, requiring intensive monitoring and sometimes recovery in the intensive care unit (ICU).

Consistent with CPT codes 39540 (acute traumatic laparotomy), the specialty societies noted that 3 minutes of pre-service positioning time is typical for an open surgical procedure, which is 12 minutes less than the recommended 15 minutes for the other laparoscopic and thoracoscopic 090-day global period services in this code family. The specialty societies also clarified that 150 minutes of intra-service time is appropriate for this service. Additional time is needed for the reduction and circumferential dissection of the identified hernia sac, beyond just repairing/closing the hernia. To reposition any herniated abdominal contents, the diaphragmatic defect may need to be enlarged. These abdominal contents and the thoracic cavity are thoroughly inspected to ensure no occult injury is missed, the chest tube is placed, the hernia margins are debrided to healthy tissue, and the defect is closed with sutures. The patient will likely require a chest tube post-operatively due to the extensive dissection of the hernia sac, which causes a sizable rent in the pleura. For further recovery and continued pain management, the patient will typically stay in the hospital for 3 days post-operatively.

To support the work RVU of 26.00, the RUC compared the surveyed code to MPC code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm,*

*pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 28.84, 150 minutes intra-service time). The RUC recognized that while this MPC reference code requires identical intra-service time as the surveyed code, it requires more total time and is a more intense/complex procedure for the physician to perform. The 25th percentile work RVU of 26.00 maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 26.00 for CPT code 39541.**

**39XX3** ***Repair, diaphragmatic hernia (other than neonatal), nontraumatic (ie, Bochdalek, Morgagni)***
The RUC reviewed survey results from 40 trauma surgeons and recommends the survey 25th percentile work RVU of 25.75, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes an elective open surgical laparotomy, which repairs a non-neonatal congenital nontraumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and laparotomy is often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs. Typically, this can occur in two locations and present as a Morgagni hernia (anterior, retrosternal or parasternal diaphragmatic defect) or a Bochdalek hernia (posterolateral diaphragmatic defect). Patients might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, congenital nontraumatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation.

For a variety of reasons, the patient elects an open surgical operation, which might simply be due to the size of the defect, making laparoscopic sewing too challenging or not tenable. Repair typically involves a larger incision and more extensive dissection in scarred tissues. In particular, the dense adhesions between herniated viscera (stomach, omentum, small bowel, colon, spleen, pancreas) and thoracic structures requires extensive adhesiolysis, which impacts operative complexity, blood loss, technical difficulty, and post-operative recovery. The larger defect often requires complex reconstruction with nonabsorbable sutures and/or prosthetic reinforcement, with close proximity to the lung and pericardium. Large chronic traumatic hernias may present with compromised lung function and displaced mediastinum, and reduction plus repair can cause abrupt shifts in intrathoracic and intra-abdominal pressures, requiring intensive monitoring and sometimes recovery in the ICU.

Consistent with CPT codes 39540 (acute traumatic laparotomy) and 39541 (chronic traumatic laparotomy), the specialty societies noted that 3 minutes of pre-service positioning time is typical for an open surgical procedure, which is 12 minutes less than the recommended 15 minutes for the other laparoscopic and thoracoscopic 090-day global period services in this code family. The specialty societies also clarified that 150 minutes of intra-service time is appropriate for this service. Like 39541, additional time is needed for the reduction and circumferential dissection of the identified hernia sac, beyond just repairing the hernia. To reposition any herniated abdominal contents, the diaphragmatic defect may need to be enlarged. These abdominal contents and the thoracic cavity are thoroughly inspected to ensure no occult injury is missed, the chest tube is placed, the hernia margins are debrided to healthy tissue, and the defect is closed with sutures. The patient will likely require a chest tube post-operatively due to the extensive dissection of the hernia sac, which causes a sizable rent in the pleura. For further recovery and continued pain management, the typical patient will stay in the hospital for 3 days post-operatively.

To support the recommended work RVU of 25.75, the RUC compared the surveyed code to the second key reference service 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time). The RUC recognized that this reference service requires more intra-service time but has a similar work RVU, which is appropriate given that the surveyed code is more intense/complex to perform.

For additional support, the RUC compared the surveyed code to MPC codes 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 20.63, 120 minutes intra-service time) and 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 28.84, 150 minutes intra-service time). The RUC recognized that the reference MPC codes bracket the survey 25$^{th}$ percentile work RVU. The surveyed code is a more intense/complex procedure to perform than 35301 and less intense/complex than 34705. Moreover, the survey 25$^{th}$ percentile work RVU of 25.75 maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 25.75 for CPT code 39XX3.**

**39XX4 *Repair, diaphragmatic hernia (other than neonatal), via thoracotomy; traumatic, chronic***
The RUC reviewed survey results from 32 trauma physicians and recommends a work RVU of 26.41 based on a direct crosswalk to CPT code 35601 *Bypass graft, with other than vein; common carotid-ipsilateral internal carotid* (work RVU = 26.41, 180 minutes intra-service time), which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 45 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 25 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes open surgical thoracotomy, which repairs a chronic traumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and thoracotomy may provide better access to the diaphragmatic defect, particularly for posterior hernias or where there is no damage to abdominal organs in the non-acute setting. A chronic traumatic hernia occurs when an acute trauma causes a tiny rupture of the diaphragm that is missed at the time of injury. Patients might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, chronic traumatic diaphragmatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation.

For a variety of reasons, the patient elects an open surgical operation, which might simply be due to the size of the defect, making laparoscopic sewing too challenging or not tenable. When compared to CPT code 39541 (chronic traumatic laparotomy) service, CPT code 39XX4 (chronic traumatic thoracotomy) requires more physician work and intra-service time to perform. For this procedure, the surgeon will enter through the chest cavity, which requires resecting a small segment of the rib posteriorly in order to explore the chest, locate the hernia, and proceed as necessary. Repair typically involves a larger incision and more extensive dissection in scarred tissues. In particular, the dense adhesions between herniated viscera (stomach, omentum, small bowel, colon, spleen, pancreas) and thoracic structures requires extensive adhesiolysis, which impacts operative complexity, blood loss,

technical difficulty, and post-operative recovery. The larger defect often requires complex reconstruction with nonabsorbable sutures and/or prosthetic reinforcement, with close proximity to the lung and pericardium. Large chronic traumatic hernias may present with compromised lung function and displaced mediastinum, and reduction plus repair can cause abrupt shifts in intrathoracic and intra-abdominal pressures, requiring intensive monitoring and sometimes recovery in the ICU.

The specialty societies noted that 45 minutes of pre-service evaluation time is necessary, which is 5 minutes more than the chronic traumatic laparotomy (CPT code 39541). This includes more time to review additional imaging and diagnostic tests performed to evaluate the patient's lung function and diaphragmatic anatomy. Additionally, 12 minutes of pre-service positioning time were added for a total of 15 minutes to account for placing the patient from supine to a lateral decubitus position, which is consistent with other 090-day global period thoracotomy procedures. These modifications to the pre-service time period package align with survey results. For this type of open surgical procedure, the patient likely requires a chest tube post-operatively due to the extensive dissection of the hernia sac and the subsequent rent left in the pleura. For this reason, patients typically stay in the hospital for 3 days post-operatively for further recovery and continued pain management. Deep breathing will be especially challenging for patients where the surgical approach was through their chest cavity.

To support the recommended work RVU of 26.41, the RUC compared the surveyed code to MPC code 22633 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 26.13, 75 minutes pre-service time, 180 minutes intra-service time). The RUC recognized that this MPC reference code requires an identical intra-service time but is less intense/complex to perform than the surveyed code.

For additional support, the RUC compared the surveyed code to CPT codes 35515 *Bypass graft, with vein; subclavian-vertebral* (work RVU = 25.44, 180 minutes intra-service time). The RUC recognized that this reference code requires identical intra-service time and describes physician work that is of comparable intensity/complexity to the surveyed code. These services support the recommended work RVU and maintain relativity within this code family and across the MFS. **The RUC recommends a work RVU of 26.41 for CPT code 39XX4.**

**39XX5 *Repair, diaphragmatic hernia (other than neonatal), via thoracotomy; nontraumatic (ie, Bochdalek, Morgagni)***
The RUC reviewed survey results from 32 trauma surgeons and recommends a work RVU of 25.94 based on a direct crosswalk to CPT code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time), which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 42 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 23 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes open surgical thoracotomy, which repairs a non-neonatal congenital nontraumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and thoracotomy may provide better access to the diaphragmatic defect, particularly for posterior hernias or where there is no damage to abdominal organs in the non-acute setting. Typically, this can occur in two locations and present as a Morgagni hernia (anterior, retrosternal or parasternal diaphragmatic defect) or a Bochdalek hernia (posterolateral diaphragmatic defect). Patients might remain asymptomatic or may

have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, congenital nontraumatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation.

The typical patient for this service is not a patient who presents symptoms in childhood, as this is not a diaphragmatic hernia where they are in respiratory distress and in the NICU. Instead, these patients typically have a diaphragmatic defect, one that was probably quite small and went unnoticed, and then later in life, started developing respiratory or GI symptoms. Similar to paraesophageal hernia repairs, these patients often become symptomatic over time, due to the diaphragmatic defect usually being quite large, and there often being significant viscera up into the chest. In some cases, the colon, spleen, pancreas, and/or stomach have all herniated up into the patient's chest.

For a variety of reasons, the patient elects an open surgical operation, which might simply be due to the size of the defect, making laparoscopic sewing too challenging or not tenable. Like CPT code 39XX4 (chronic traumatic thoracotomy), this service requires more physician work and intra-service time to perform than the chronic traumatic laparotomy (39541) and congenital nontraumatic laparotomy (39XX3) services. The surgeon must enter through the chest cavity, which requires resecting a small segment of the rib posteriorly in order to explore the chest, locate the hernia, and proceed as necessary. Repair typically involves a larger incision and more extensive dissection in scarred tissues. In particular, the dense adhesions between herniated viscera (stomach, omentum, small bowel, colon, spleen, pancreas) and thoracic structures requires extensive adhesiolysis, which impacts operative complexity, blood loss, technical difficulty, and post-operative recovery. The larger defect often requires complex reconstruction with nonabsorbable sutures and/or prosthetic reinforcement, with close proximity to the lung and pericardium. Large chronic traumatic hernias may present with compromised lung function and displaced mediastinum, and reduction plus repair can cause abrupt shifts in intrathoracic and intra-abdominal pressures, requiring intensive monitoring and sometimes recovery in the intensive care unit (ICU).

The specialty societies noted that 42 minutes of pre-service evaluation time is necessary, which is 2 minutes more than the congenital nontraumatic laparotomy (39XX3) and 3 minutes less than the chronic traumatic thoracotomy (39XX4). This includes sufficient time to review additional imaging and diagnostic tests performed to evaluate the patient's lung function and diaphragmatic anatomy. Moreover, 12 minutes of pre-service positioning time were added for a total of 15 minutes to account for placing the patient from supine to a lateral decubitus position, which is consistent with other 090-day global period thoracoscopic procedures. These modifications to the pre-service time period package align with survey results. For this type of open surgical procedure, the patient likely requires a chest tube post-operatively due to the extensive dissection of the hernia sac and the subsequent rent left in the pleura. For this reason, patients typically stay in the hospital for 3 days post-operatively for further recovery and continued pain management. Deep breathing will be especially challenging for patients where the surgical approach was through their chest cavity.

To support the recommended work RVU of 25.94, the RUC compared surveyed code to MPC code 22633 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 26.13, 75 minutes pre-service time, 180 minutes intra-service time). The RUC recognized that this MPC reference code requires an identical intra-service time but is less intense/complex to perform than the surveyed code.

For additional support, the RUC compared the surveyed code to CPT codes 35515 *Bypass graft, with vein; subclavian-vertebral* (work RVU = 25.44, 180 minutes intra-service time). The RUC recognized that this reference code requires identical intra-service time and describes physician work that is of comparable intensity/complexity to the surveyed code. These services support the recommended work RVU and maintain relativity within this code family and across the MFS. **The RUC recommends a work RVU of 25.94 for CPT code 39XX5.**

**39XX7** ***Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, acute***

The RUC reviewed survey results from 47 trauma surgeons and recommends the survey 25th percentile work RVU of 22.04, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes laparoscopic surgical repair of an acute traumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and laparoscopy is often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs. This is a very different clinical scenario and patient population than the chronic traumatic laparoscopy (39XX8) and nontraumatic congenital laparoscopy (39XX9) procedures in this code family. Acute diaphragmatic hernias are typically caused by a traumatic incident that creates a defect in the diaphragm as a result of a sudden increase in intra-abdominal pressure, which, in this clinical scenario, is a smaller, discreet, or penetrating injury (e.g., a knife or bullet wound). After receiving a CT scan, there will be an indication that the patient has sustained a diaphragmatic injury, wherein viscera are slipping up into the chest, and blood and/or air may be visible on both sides of the diaphragm. As part of the pre-service work for this service, the surgeon will need to review the length and type of anesthesia with the anesthesiologist and coordinate with other surgical specialties that may be involved to discuss the sequence, timing, and scope of all necessary procedures.

The typical patient has a defect through their diaphragm, but they are in stable enough condition that the surgeon determines a less invasive laparoscopic approach is a viable intervention. The surgeon will use abdominal access to inspect and confirm whether or not there may be an occult injury, possibly to the colon, spleen, pancreas, and/or stomach, as well as anything else in that area. Barring that all the blood is cleared, the surgeon will evaluate all viscera and see that the only injury is a small defect in the diaphragm, which would then be laparoscopically repaired.

Consistent with other 090-day global period laparoscopic and thoracoscopic services in this code family, 15 minutes of pre-service positioning time is required for this procedure, which is 12 minutes more than the recommended 3 minutes for the other open surgical laparotomy codes (CPT codes 39540, 39541, 39XX3). The patient will initially be positioned supine, and upper extremity intravenous and arterial access points are dressed, padded, and secured. Their arms are padded and tucked in at the patient's sides. The patient is secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. Positioning is also determined relative to the laparoscopy equipment, including the lines and video equipment, and anesthesia lines, relative to the rest of the equipment. The abdomen is marked and prepared from the groin to the clavicles to reach the thorax and abdomen if an emergent thoracotomy or laparotomy is needed.

The specialty societies also clarified that 120 minutes of intra-service time is appropriate for this service. Compared to CPT codes 39XX8 (chronic traumatic laparoscopy) and 39XX9 (congenital nontraumatic laparoscopy), which both require 180 minutes of intra-service time, this service requires less intraoperative time since the physician does not need to perform extensive dissection/reduction of a hernia sac. Instead, the surgeon will be detecting and repairing the identified defect, as well as evaluating for further injury. Notably, these services all have similar overall intensity/complexity to perform but for different clinical reasons. The specialty society explained that this surgery is performed in an acute setting where there is great concern for missing some other severe occult injury; however, the physician is not required to, for example, meticulously dissect the pancreas out of a hernia sac that is attached to the pleura. For CPT code 39XX7, the surgery is still performed in a high-intensity acute setting but requires less intraoperative time and physician work overall compared to the other laparoscopic services in this code family due to the isolated nature of the patient's injury. The RUC acknowledged this distinction, recognizing the similarity in intensity/complexity but differences in clinical scenario and patient population. Additionally, the patient will likely require a chest tube during surgery, so for further recovery and continued pain management, the patient will typically stay in the hospital for 3 days post-operatively.

To support the recommended work RVU of 22.04, the RUC compared the surveyed code to the top key reference service 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time). The RUC recognized that this reference service requires more intra-service time and similar total time, but is less intense/complex than the surveyed code.

For additional support, the RUC compared the surveyed code to MPC codes 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 20.63, 120 minutes intra-service time). The RUC recognized that the reference MPC code has identical intra-service time as the surveyed code but requires less total time and is less intense/complex to perform, which maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 22.04 for CPT code 39XX7.**

**39XX8 *Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, chronic***

The RUC reviewed survey results from 42 trauma surgeons and recommends the survey 25$^{th}$ percentile work RVU of 26.60, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 30 minutes of immediate post-service time, 1-99232 hospital visit, 1-99231 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes laparoscopic surgical repair of a chronic traumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and laparoscopy is often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs. A chronic traumatic hernia occurs when an acute trauma causes a tiny rupture of the diaphragm that is missed at the time of injury. The typical patient might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, chronic traumatic diaphragmatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation. In some cases, the colon, spleen, pancreas, and/or stomach have all herniated up into the patient's chest.

CPT code 39XX8 is an elective surgery, and a laparoscopic approach is determined to be a viable intervention. Consistent with other 090-day global period laparoscopic and thoracoscopic services in this code family, 15 minutes of pre-service positioning time is required for this procedure, which is 12 minutes more than the recommended 3 minutes for the other open surgical codes (CPT codes 39540, 39541, 39XX3). The patient will initially be positioned supine, and upper extremity intravenous and arterial access points are dressed, padded, and secured. Their arms are padded and tucked in at the patient's sides. The patient is secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. Positioning is also determined relative to the laparoscopy equipment, including the lines and video equipment, and anesthesia lines, relative to the rest of the equipment. The abdomen is marked and prepared from the groin to the clavicles to reach the thorax and abdomen if an emergent thoracotomy or laparotomy is needed.

The specialty societies also clarified that 180 minutes of intra-service time is appropriate for this service, clarifying that additional time compared to CPT code 39XX7 (acute traumatic laparoscopy) is needed for the reduction and circumferential dissection of the identified hernia sac, beyond just repairing the hernia. To reposition any herniated abdominal contents, the diaphragmatic defect may need to be enlarged. These abdominal contents and the thoracic cavity are thoroughly inspected to ensure no occult injury is missed, the chest tube is placed, the hernia margins are debrided to healthy tissue, and the defect is closed with sutures. It is technically demanding to perform due to chronic adhesions, distorted anatomy, and the risk of injuring the adherent lung or bowel; conversion to open or thoracic approaches is more common if reduction is unsafe. Large defects may be closed with non-bridging mesh or tailored flaps, and intraoperative decisions about thoracic drains are frequent. The patient will likely require a chest tube post-operatively due to the extensive dissection of the hernia sac, which causes a sizable rent in the pleura. For further recovery and continued pain management, the typical patient will stay in the hospital for 3 days post-operatively.

To support the recommended work RVU of 26.60, the RUC compared the surveyed code to the top key reference service 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 29.35, 210 minutes intra-service time) and second key reference service 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time). The RUC recognized that these two key reference services require similar physician work and overall time, and together, they bracket the survey 25$^{th}$ percentile work RVU.

For additional support, the RUC compared the surveyed code to 22633 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 26.13, 75 minutes pre-service time, 180 minutes intra-service time). The RUC recognized that this MPC reference code requires identical intra-service time and similar intensity/complexity as the surveyed code. Moreover, the survey 25$^{th}$ percentile work RVU maintains relativity with this code family and across the MFS. **The RUC recommends a work RVU of 26.60 for CPT code 39XX8.**

**39XX9 *Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); nontraumatic (ie, Bochdalek, Morgagni)***

The RUC reviewed survey results from 44 trauma surgeons and recommends the survey 25$^{th}$ percentile work RVU of 27.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 180 minutes

of intra-service time, 30 minutes of immediate post-service time, 1-99232 hospital visit, 1-99321 hospital visit, 1-99238 discharge visit, and 2-99213 office visits.

The physician work involved with this service describes laparoscopic surgery of a non-neonatal nontraumatic congenital hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and laparoscopy is often used for an anterior hernia as it allows for the ability to assess the entire abdominal cavity with better identification and manipulation of the herniated organs. Typically, this can occur in two locations and present as a Morgagni hernia (anterior, retrosternal or parasternal diaphragmatic defect) or a Bochdalek hernia (posterolateral diaphragmatic defect). Patients might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, congenital nontraumatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation.

The typical patient might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, these patients often become symptomatic over time due to the diaphragmatic defect usually being quite large, and there are often significant viscera located in the patient's chest. In some cases, the colon, spleen, pancreas, and/or stomach have all herniated up into the patient's chest.

Like CPT code 39XX8 (chronic traumatic laparoscopy), CPT code 39XX9 is an elective surgery, and a laparoscopic approach is determined to be a viable intervention. Consistent with other 090-day global period laparoscopic and thoracoscopic services in this code family, 15 minutes of pre-service positioning time is required for this procedure, which is 12 minutes more than the recommended 3 minutes for the other open surgical codes (CPT codes 39540, 39541, 39XX3). The patient will initially be positioned supine, and upper extremity intravenous and arterial access points are dressed, padded, and secured. Their arms are padded and tucked in at the patient's sides. The patient is secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. Positioning is also determined relative to the laparoscopy equipment, including the lines and video equipment, and anesthesia lines, relative to the rest of the equipment. The abdomen is marked and prepared from the groin to the clavicles to reach the thorax and abdomen if an emergent thoracotomy or laparotomy is needed.

The specialty societies also clarified that 180 minutes of intra-service time is appropriate for this service, clarifying that additional time compared to CPT code 39XX7 (acute traumatic laparoscopy) is needed for the reduction and circumferential dissection of the identified hernia sac, beyond just repairing the hernia (which is consistent with CPT code 39XX8, chronic traumatic laparoscopy). To reposition any herniated abdominal contents (such as organs), the diaphragmatic defect may need to be enlarged. These abdominal contents and the thoracic cavity are thoroughly inspected to ensure no occult injury is missed, the chest tube is placed, the hernia margins are debrided to healthy tissue, and the defect is closed with sutures. Though this service is not commonly performed, the primary goal is to reduce the viscera contents, excise the hernia sac, and fix/close the diaphragmatic defect. It is technically demanding to perform due to chronic adhesions, distorted anatomy, and the risk of injuring the adherent lung or bowel; conversion to open or thoracic approaches is more common if reduction is unsafe. Large defects may be closed with non-bridging mesh or tailored flaps, and intraoperative decisions about thoracic drains are frequent. The patient will likely require a chest tube post-operatively due to the extensive dissection of the hernia sac, which causes a sizable rent in the pleura. For further recovery and continued pain management, the typical patient will stay in the hospital for 3 days post-operatively.

To support the recommended work RVU of 27.00, the RUC compared the surveyed code to the top key reference service 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 29.35, 210 minutes intra-service time) and second key reference service 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time). Like 39XX8, the RUC recognized that these two key reference services require similar physician work and time, and together, they bracket the survey 25th percentile work RVU for 39XX9.

For additional support, the RUC compared the surveyed code to 22633 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 26.13, 75 minutes pre-service time, 180 minutes intra-service time). The RUC recognized that this MPC reference code requires identical intra-service time and similar intensity/complexity as the surveyed code. Moreover, the survey 25th percentile work RVU maintains relativity with this code family and across the MFS. **The RUC recommends a work RVU of 27.00 for CPT code 39XX9.**

**39X11** ***Thoracoscopy surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, chronic***

The RUC reviewed survey results from 32 trauma surgeons and recommends the survey median work RVU of 25.44, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 41 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 180 minutes of intra-service time, 20 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99238 discharge visit, and 1-99213 office visit.

The physician work involved with this service describes thoracoscopic surgical repair of a chronic traumatic hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and thoracoscopy may provide better access to the diaphragmatic defect, particularly for posterior hernias or where there is no damage to abdominal organs in the non-acute setting. A chronic traumatic hernia occurs when an acute trauma causes a tiny rupture of the diaphragm that is missed at the time of injury. The typical patient might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, chronic traumatic diaphragmatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation. In some cases, the colon, spleen, pancreas, and/or stomach have all herniated up into the patient's chest.

CPT code 39X11 is an elective surgery, and a thoracoscopic approach is determined to be a viable intervention. Consistent with other 090-day global period laparoscopic and thoracoscopic services in this code family, 15 minutes of pre-service positioning time is required for this procedure, which is 12 minutes more than the recommended 3 minutes for the other open surgical codes (CPT codes 39540, 39541, 39XX3). The patient will initially be positioned supine, and upper extremity intravenous and arterial access points are dressed, padded, and secured. Their arms are padded and tucked in at the patient's sides. The patient is secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. Positioning is also determined relative to the thoracoscopy equipment, including the lines and video equipment, and anesthesia lines, relative to the rest of the equipment. The abdomen is marked and prepared from the groin to the clavicles to reach the thorax and abdomen if an emergent thoracotomy or laparotomy is needed.

The specialty societies also clarified that 180 minutes of intra-service time is appropriate for this service, clarifying that additional time compared to CPT code 39XX7 (acute traumatic laparoscopy) is needed for the reduction and circumferential dissection of the identified hernia sac, beyond just repairing the hernia. To reposition any herniated abdominal contents (such as organs), the diaphragmatic defect may need to be enlarged. These abdominal contents and the thoracic cavity are thoroughly inspected to ensure no occult injury is missed, the chest tube is placed, the hernia margins are debrided to healthy tissue, and the defect is closed with sutures. Though this service is not commonly performed, the primary goal is to reduce the viscera contents, excise the hernia sac, and fix/close the diaphragmatic defect. It is technically demanding to perform due to chronic adhesions, distorted anatomy, and the risk of injuring the adherent lung or bowel; conversion to open or thoracic approaches is more common if reduction is unsafe. Large defects may be closed with non-bridging mesh or tailored flaps, and intraoperative decisions about thoracic drains are frequent. The patient will likely require a chest tube post-operatively due to the extensive dissection of the hernia sac, which causes a sizable rent in the pleura. For further recovery and continued pain management, the typical patient will stay in the hospital for 3 days post-operatively.

To support the recommended work RVU of 25.44, the RUC compared the surveyed code to MPC code 22633 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 26.13, 75 minutes pre-service time, 180 minutes intra-service time). The RUC recognized that this MPC reference code requires an identical intra-service time and requires similar intensity/complexity as the surveyed code.

For additional support, the RUC compared the surveyed code to CPT code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time). The RUC recognized that this reference code requires identical intra-service time, nearly identical total time, and similar intensity/complexity to perform than the surveyed code, which is appropriate given its slightly higher work RVU. The recommended survey median work RVU of 25.44 maintains relativity within this code family and across the MFS. **The RUC recommends a work RVU of 25.44 for CPT code 39X11.**

**39X12** ***Thoracoscopy surgical, with repair of diaphragmatic hernia (other than neonatal); nontraumatic (ie, Bochdalek, Morgagni)***
The RUC reviewed survey results from 32 trauma surgeons and recommends a work RVU of 25.94 based on a direct crosswalk to CPT code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 25.94, 180 minutes intra-service time), which appropriately accounts for the physician work required to perform this service. The RUC recommends 41 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 170 minutes of intra-service time, 20 minutes of immediate post-service time, 1-99233 hospital visit, 1-99232 hospital visit, 1-99238 discharge visit, and 1-99213 office visit.

The physician work involved with this service describes thoracoscopic surgical repair of a non-neonatal nontraumatic congenital hernia in the patient's diaphragm. The surgical approach for this type of procedure is largely dependent on patient presentation, and thoracoscopy may provide better access to the diaphragmatic defect, particularly for posterior hernias or where there is no damage to abdominal organs in the non-acute setting. Typically, this can occur in two locations and present as a Morgagni hernia (anterior, retrosternal or parasternal diaphragmatic defect) or a Bochdalek hernia (posterolateral diaphragmatic defect). Patients might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they

begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, congenital nontraumatic hernias are typically very large, with extensive visceral contents due to their delayed and late presentation.

The typical patient might remain asymptomatic or may have delayed complications, months, years, or decades later, until an occult trauma is later identified, when they begin presenting respiratory or GI symptoms. Similar to paraesophageal hernia repairs, these patients often become symptomatic over time due to the diaphragmatic defect usually being quite large, and there are often significant viscera located in the patient's chest. In some cases, the colon, spleen, pancreas, and/or stomach have all herniated up into the patient's chest.

Like CPT code 39X11 (chronic traumatic thoracoscopy), CPT code 39X12 is an elective surgery, and a thoracoscopic approach is determined to be a viable intervention. Consistent with other 090-day global period laparoscopic and thoracoscopic services in this code family, 15 minutes of pre-service positioning time is required for this procedure, which is 12 minutes more than the recommended 3 minutes for the other open surgical codes (CPT codes 39540, 39541, 39XX3). The patient will initially be positioned supine, and upper extremity intravenous and arterial access points are dressed, padded, and secured. Their arms are padded and tucked in at the patient's sides. The patient is secured to the table, including a soft chest and thigh strap, as it may be necessary to roll the table during the procedure to use gravity to assist with shifting the abdominal contents. Positioning is also determined relative to the laparoscopy equipment, including the lines and video equipment, and anesthesia lines, relative to the rest of the equipment. The abdomen is marked and prepared from the groin to the clavicles to reach the thorax and abdomen if an emergent thoracotomy or laparotomy is needed.

The specialty societies also clarified that 170 minutes of intra-service time is appropriate for this service, clarifying that additional time compared to CPT code 39XX7 (acute traumatic laparoscopy) is needed for the reduction and circumferential dissection of the identified hernia sac, beyond just repairing the hernia. The RUC recognized that survey respondents determined that this service requires 10 fewer minutes of intra-service time than chronic traumatic thoracoscopy (39X11), which may account for minor differences in patient population for certain cases (i.e., the size and location of the hernia sac). To reposition any herniated abdominal contents, the diaphragmatic defect may need to be enlarged. These abdominal contents and the thoracic cavity are thoroughly inspected to ensure no occult injury is missed, the chest tube is placed, the hernia margins are debrided to healthy tissue, and the defect is closed with sutures. Though this service is not commonly performed, the primary goal is to reduce the viscera contents, excise the hernia sac, and fix/close the diaphragmatic defect. It is technically demanding to perform due to chronic adhesions, distorted anatomy, and the risk of injuring the adherent lung or bowel; conversion to open or thoracic approaches is more common if reduction is unsafe. Large defects may be closed with non-bridging mesh or tailored flaps, and intraoperative decisions about thoracic drains are frequent. The patient will likely require a chest tube post-operatively due to the extensive dissection of the hernia sac, which causes a sizable rent in the pleura. For further recovery and continued pain management, the typical patient will stay in the hospital for 3 days post-operatively.

To support the recommended work RVU of 25.94, the RUC compared the surveyed code to MPC code 22633 *Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 26.13, 75 minutes pre-service time, 180 minutes intra-service time). The RUC recognized that this MPC reference code requires similar intra-service time and requires similar intensity/complexity as the surveyed code.

For additional support, the RUC compared the surveyed code to CPT codes 35515 *Bypass graft, with vein; subclavian-vertebral* (work RVU = 25.44, 180 minutes intra-service time) and 44204 (work RVU = 25.76, 180 minutes intra-service time). The RUC recognized that this reference code requires identical intra-service time and describes physician work that is of comparable intensity/complexity to the surveyed code. These services support the recommended work RVU and maintain relativity within this code family and across the MFS. **The RUC recommends a work RVU of 25.94 for CPT code 39X12.**

**39X13** ***Implantation of mesh or other prosthesis with open, laparoscopic, or thoracoscopic diaphragmatic hernia repair (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 47 trauma surgeons and recommends a work RVU of 3.00 based on a direct crosswalk to CPT code 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)* (work RVU = 3.00, 30 minutes intra-service time), which appropriately accounts for the physician work typically required to perform this add-on service. The RUC recommends 30 minutes of intra-service time.

The specialty societies explained that this add-on service can be used in addition to any of the diaphragmatic hernia repair services in this code family (i.e., laparotomy, thoracotomy, laparoscopy, or thoracoscopy). Implantation of mesh is not typical but may be necessary depending on the patient, the size of the defect, and whether the native tissues are inadequate for a durable tension-free repair. The physician work involved with this service describes creating a preperitoneal flap, placing the mesh, suturing the mesh around the edges, and then closing the preperitoneal flap.

To support the recommended work RVU of 3.00, the RUC compared the surveyed code to several lower extremity revascularization codes implemented in 2026 with 30 minutes intra-service time and a work RVU of 3.00, including: 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)*, 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)*, 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)*, 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 recommends a work RVU of 3.00 for CPT code 39X13.**

**Practice Expense**
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

**Prostate Biopsy Services (Tab 12)**
**Curtis Anderson, MD (OEIS), Michael Booker, MD (ACR), Seth Cohen, MD (AUA), Minhajuddin Khaja, MD (SIR), Jonathan Kiechle, MD (AUA), Andrew Moriarity, MD (ACR)**

In April 2022, the Relativity Assessment Workgroup (RAW) identified services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. Further, any code pairs in which one of the codes was either below 1,000 in 2020 Medicare claims data and/or containing at least one ZZZ global service were removed. The RAW requested action plans for September 2022 to determine if specific code bundling solutions should occur for 55700 and 76872. In September 2022, the RAW referred this issue to the CPT Editorial Panel for revision of code descriptors and/or introductory language to clarify when to and when not to report CPT code 76872 as a diagnostic procedure when performed at the same time as CPT code 55700. In May 2024, the CPT Editorial Panel deleted existing code 55700, revised codes 55705 and 76872, and added nine codes to clarify reporting for prostate biopsies and the imaging procedures that accompany them. The code family was surveyed for the September 2024 RUC meeting.

During the RUC discussion in September 2024, the specialties asserted that the survey respondents did not understand the coding structure. Specifically, the discussion revolved around the number of biopsies per code and the time to perform the number of biopsies and the time to perform the number of biopsies. A typical prostate biopsy, at minimum, requires 12-cores. The prostate is divided into sextants, and two biopsies are taken from each sextant for a 12-core biopsy. The transperineal approach to biopsy has changed the standard template by increasing the typical number of biopsies to 20, due to the improved access to the anterior portion of the prostate. MRI-fusion technology is used in conjunction with this standard template biopsy. When a lesion is identified on pre-biopsy MRI that requires specific targeting, taking biopsies of only a suspicious lesion is not typical practice. It is important to note that each biopsy is taken individually and the retrieved specimen is placed in a separate cup for pathological evaluation. From a survey standpoint, the data from the September 2024 survey indicated that the long descriptors did not adequately describe these services. While the codes were valued for the CPT 2026 cycle, the specialties and the RUC agreed that a new coding change application should be developed for the CPT Editorial Panel for restructuring in the CPT 2027 cycle. In September 2024, the RUC recommended referring the prostate biopsy services code family to the CPT Editorial Panel for restructuring in the CPT 2027 cycle.

The RUC recommended changes to the long descriptor language and related guidelines to better describe the services and number of biopsies performed per service. Additionally, the language of "first targeted lesion" was not clear to RUC members and the survey respondents, as indicated by the identical intra-service times for services where few biopsies were obtained and services where numerous biopsies were obtained. Another RUC member noted that the language "Biopsy" and "Biopsies" was confusing as well. Additionally, the add-on code was thought to present a potential issue for improper coding due to a lack of clarity on the number of biopsies performed per service. The societies informed the RUC that they would submit a Coding Change Application (CCA) for the CPT 2027 cycle. At the September 2025 CPT Editorial Panel meeting, the code family was revised to clarify the number of biopsies per code, and two existing codes were deleted. The prostate biopsy code family was surveyed for the January 2026 RUC meeting.

**55705** ***Biopsy, prostate, any approach, non-imaging guided***
The RUC reviewed the survey results from 82 urologists and determined that the current work RVU of 1.88 appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC recommends 16 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 9 minutes immediate post-service time.

The specialty societies noted that the lack of imaging guidance for this service results in significant procedural intensity. During this procedure, the surgeon must identify the prostate and any specific concerning nodules with finger guidance alone. The biopsy instrument is then introduced, using only the performing surgeon's opposite hand finger as a guide. Significant care must be taken to ensure adequacy of the biopsy samples, while simultaneously avoiding self-injury when performing this procedure, due to the non-imaging guided nature of the procedure. The specialty societies noted that this service typically has 12 biopsy samples via a finger approach. Given that this service is only done in the circumstance when an ultrasound machine is not available, which is atypical across the country, this service's utilization is expected to be quite low.

To support the recommended work RVU, the RUC compared the surveyed code to the 2nd key reference code 52000 *Cystourethroscopy (separate procedure)* (work RVU =1.49, intra-service time = 10 minutes) and noted that although both services involve the same amount of intra-service time, cystourethroscopy typically involves less total time. Also, 56 percent of the survey respondents who selected this key reference service indicated that the surveyed code is a more intense service to perform. The RUC also compared the surveyed code to CPT code 31576 *Laryngoscopy, flexible; with biopsy(ies)* (work RVU = 1.84, intra-service time =10 minutes) and noted that both services involve the same amount of intra-service time, whereas the surveyed code involves more total time. **The RUC recommends a work RVU of 1.88 for CPT code 55705.**

**55707** ***Biopsy, prostate, transrectal, including imaging guidance, regional***
The RUC reviewed the survey results from 129 urologists and determined that the current work RVU of 2.63 appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC recommends 16 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 7 minutes immediate post-service time. Imaging guidance is bundled into this procedure and cannot be separately reported.

The specialty noted that the typical patient will have 12 biopsies obtained in a traditional sextant pattern proceeding from the left lateral base of the prostate to the right medial apex to sample the prostate gland. During the procedure, a topical anesthetic is administered, and the ultrasound probe is placed transrectally.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 52284 *Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed* (work RVU = 3.02, intra-service time =20 minutes) and noted that the surveyed code involves less intra-service and total time and both services involve bundled imaging guidance and maintain the appropriate relativity to each other. The RUC also compared the surveyed code to MPC code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU =3.12, intra-service time = 21 minutes) and noted that the reference code typically involves more intra-service and total time. **The RUC recommends a work RVU of 2.63 for CPT code 55707.**

**55708** ***Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)***
The RUC reviewed the survey results from 113 urologists and determined that the current work RVU of 3.39 appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC recommends 20 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 17 minutes intra-service time, and 10 minutes immediate post-service time. Imaging guidance is bundled into this procedure and cannot be separately reported.

Within the code family, this procedure is more complex when compared to code 55707 due to the addition of the MRI fusion work. For this procedure, prior MRI imaging needs to be fused with real-time ultrasound imaging to identify the target lesion. Adequate prostate ultrasound images must be obtained and manually confirmed to ensure that the appropriate fusion of the MRI image has taken place. The target lesion(s) must be located on the ultrasound, and typically, two biopsies will be taken out of each target lesion. Following the biopsy of the target lesion, 12 additional biopsies are obtained in the traditional sextant pattern. The typical patient has one target lesion and 14 biopsies.

The RUC agreed that the minimal difference in times between the 2025 survey and the 2024 survey was immaterial and supported the current value.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU =3.12, intra-service time = 21 minutes) and noted that although the reference code involves somewhat more intra-service time, it involves a similar amount of total time and is a less intense service to perform. The RUC also compared the surveyed code to CPT code 43250 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU = 2.90, intra-service time =20 minutes) and noted that although the surveyed code involves somewhat less intra-service time, it involves somewhat more total time and is a somewhat more intense service to perform. **The RUC recommends a work RVU of 3.39 for CPT code 55708.**

**55709** ***Biopsy, prostate, transperineal, including imaging guidance, regional***
The RUC reviewed the survey results from 92 urologists and determined that the current work RVU of 3.23 appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC recommends 22 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. Imaging guidance is bundled into this procedure and cannot be separately reported.

For this procedure, the typical transperineal prostate biopsy entails 20 biopsies to be obtained. This includes the typical sextant biopsies with an additional 8 biopsies taken from the anterior prostate. The transperineal approach allows for much easier access to this anterior location, which is not typically biopsied from a transrectal approach. The patients who receive this procedure either have not undergone prior MRI or have undergone MRI with no suspicious lesion identified. During the procedure, a topical anesthetic is administered, and the ultrasound probe is placed transrectally. The prostate is identified and evaluated for any hyperechoic areas on the ultrasound. Local anesthesia is then injected through the perineum, and 20 biopsies are obtained, including any hyperechoic areas, using the transperineal biopsy guide to assist with the stability of the ultrasound probe throughout the biopsy process.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU =3.12, intra-service tim e= 21 minutes) and noted that although the reference code involves slightly more intra-service time, it involves somewhat less total time. The RUC also compared the surveyed code to CPT code 43250 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU = 2.90, intra-service time =20 minutes) and noted that although both procedures typically involve the same intra-service time, the surveyed code involves somewhat more total time. **The RUC recommends a work RVU of 3.23 for CPT code 55709.**

**55710** ***Biopsy, prostate, transperineal, including imaging guidance, regional and of fusion-targeted lesion(s)***
The RUC reviewed the survey results from 86 urologists and determined that the current work RVU of 3.81 appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC recommends 24 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 22 minutes intra-service time, and 10 minutes immediate post-service time. Imaging guidance is bundled into this procedure and cannot be separately reported. For CPT 2027, this code has been revised to now include one or more lesions.

For this procedure, the typical number of biopsies obtained is 22, including identification of a target lesion using MRI fusion guidance. Further, adequate prostate ultrasound images must be obtained, and appropriate fusion of these images with the prior MRI must be confirmed manually by the physician. The target lesion must be located on the ultrasound, and multiple biopsies must be obtained of the target lesion. Following the biopsy of the target lesion, complete sextant biopsies, including the anterior zone, are obtained. This procedure is more complex when compared to code 55709 due to the addition of the MRI fusion work and the second-highest complexity to perform within the code family.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU = 3.90, intra-service time = 25 minutes) and noted that the reference code involves somewhat more intra-service and total time. The RUC also compared the surveyed code to MPC code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU=3.12, intra-service time= 21 minutes) and noted that the surveyed code involves somewhat more intra-service and total time and is a more intense service to perform. **The RUC recommends a work RVU of 3.81 for CPT code 55710.**

**55711** ***Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; first targeted lesion***
The RUC reviewed the survey results from 95 urologists and determined a direct work RVU crosswalk to CPT code 31574 *Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral* (work RVU= 2.37, intra-service time= 15 minutes) appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC noted that both services typically involve the same amount of intra-service time, total time and physician work intensity. The RUC recommends 20 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 10 minutes immediate post-service time. Imaging guidance is bundled into this procedure and cannot be separately reported. For CPT 2027, this revised code has changed relative to its CPT 2026 iteration, where now it is only for the first targeted lesion, it is

without regional biopsies, and it includes either the transrectal or transperineal approach. The new code structure combined the transperineal and transrectal approaches, with the transrectal typical.

For this procedure, prior MRI imaging is fused with real-time ultrasound imaging to identify the target lesion. The ultrasound probe is placed using either a transrectal or transperineal approach. The target lesion is identified after the appropriate fusion, imaging is obtained, and the targeted lesion is biopsied. This procedure typically requires three biopsies to be obtained from the targeted lesion to adequately sample the lesion. This code describes the first lesion being biopsied via either the transperineal or transrectal approach. It will only be used when regional biopsies are not obtained.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 52284 *Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed* (work RVU = 3.02, intra-service time =20 minutes) and noted that the surveyed code involves less intra-service and total time and both services involve bundled imaging guidance and would have appropriate relativity to each other. The RUC also compared the surveyed code to MPC code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU =3.12, intra-service time = 21 minutes) and noted that the reference code typically involves more intra-service and total time. **The RUC recommends a work RVU of 2.37 for CPT code 55711.**

**5XX14** ***Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; each additional targeted lesion (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 89 urologists and determined that the 25$^{th}$ percentile work RVU of 0.80 appropriately accounts for the physician work required to perform this service. The RUC recommends 6 minutes of intra-service and total time. The RUC noted that this service is an add-on code to 55711 for each additional targeted lesion and that an add-on code to report each additional fusion-targeted lesion without regional did not exist in the prior code structure. The CPT 2027 iteration of this code descriptor changed significantly compared to its CPT 2026 counterpart, where now it is an add-on code for each subsequent lesion after 55711 is reported. The RUC understands that the CPT Editorial Panel will be considering renumbering this service as the CPT 2026 code descriptor is substantially different than the CPT 2027 descriptor and the the coding change was not editorial.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 93584 *Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)* (work RVU=1.17, intra-service time= 10 minutes) and noted that the surveyed code involves less intra-service and total time. The RUC also compared the surveyed code to MPC code 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)* (work RVU = 0.98, intra-service time = 10 minutes) and noted that the surveyed code involves less intra-service and total time. **The RUC recommends a work RVU of 0.80 for CPT code 5XX14.**

**55714** ***Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; first targeted lesion***

The RUC reviewed the survey results from 32 diagnostic and interventional radiologists and determined that the current work RVU of 3.62 appropriately accounts for the physician work required to perform this service, as supported by the physician work survey time data. The RUC recommends

39 minutes pre-service evaluation time, 18 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 38 minutes intra-service time, and 15 minutes immediate post-service time. Imaging guidance is bundled into this procedure and cannot be separately reported.

For this procedure, a biopsy of a single targeted lesion, in-bore, with two biopsies is typically obtained. This procedure includes real-time imaging guidance in-bore, where images are acquired and utilized for the purpose of lesion localization, and avoidance of complex neurovascular structures as the biopsy device is advanced and targeted with re-imaging as needed, followed by the biopsy. This procedure does not include the fusion of previously acquired imaging with real-time ultrasound guidance, as other codes in the family have required.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 19085 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance* (work RVU =3.55, intra-service time = 45 minutes) and noted that although the surveyed code involves somewhat less intra-service time, it includes much more total time. The RUC also compared the surveyed code to 2nd key reference code 19081 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance* (work RVU = 3.21, intra-service tim e= 30 minutes) and noted that the surveyed code involves more intra-service and total time, thus is appropriately valued higher. **The RUC recommends a work RVU of 3.62 for CPT code 55714.**

**55715** ***Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; each additional targeted lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 30 diagnostic and interventional radiologists and determined that the 25th percentile work RVU of 1.80 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes intra-service and total time. Imaging guidance is bundled into this procedure and cannot be separately reported.

CPT code 55715 is an add-on procedure that has changed substantially compared to its legacy descriptor that was last surveyed in 2024. The legacy code structure of this add-on code which was surveyed in 2024 survey for CPT 2026 was to be used regardless of biopsy approach when an additional target lesion is identified on the MRI beyond the first lesion. For CPT 2027 and beyond, 55715 has changed to only be reported with base code CPT code 55714. Due to this coding change, radiology is expected to be the dominant specialty going forward and a fusion guided biopsy is replaced with an in-bore MRI-guided biopsy. Code 55715 represents a biopsy of a single additional targeted lesion, in-bore, with two biopsies typically obtained. This procedure includes real-time imaging guidance in-bore, where images are acquired and utilized for the purpose of lesion localization, and avoidance of complex neurovascular structures as the biopsy device is advanced and targeted with re-imaging as needed, followed by the biopsy. This procedure does not include the fusion of previously acquired imaging with real-time ultrasound guidance, as other codes in the family have required.

To support the recommended work RVU, the RUC compared the surveyed code top key reference code 19086 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)* (work RVU = 1.77, intra-service time = 38 minutes) and noted that the surveyed code involves somewhat less intra-service and total time. However, 75 percent of the survey respondents who selected this key reference indicated that the surveyed code is more intense and

complex to perform. The RUC also compared the surveyed code to 2nd key reference code 19082 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)* (work RVU = 1.61, intra-service time= 25 minutes) and noted that the surveyed code involves more intra-service and total time. Also, 67 percent of the respondents who selected this key reference indicated that the surveyed code is more intense and complex to perform. **The RUC recommends a work RVU of 1.80 for CPT code 55715.**

**Affirm RUC Recommendations**
**The RUC affirms the current physician time of 6 minutes pre-evaluation time, 10 minutes intra-service time, 7 minutes immediate post-service work and work value of 0.65 for CPT code 76872.**

**Practice Expense**
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made several minor modifications to the recommendations from the specialty societies. For supply code SL036 *cup, biopsy specimen sterile 4oz* and SL072 *formalin*, the PE Subcommittee corrected the amounts to reflect the typical number of biopsies for codes 55708 and 55710, which typically include 14 and 22 biopsies, respectively. Therefore, SL036 was changed to 14 cups for 55708 and 22 cups for 55710. Similarly, since 4 oz (or 120ml) of formalin is required per biopsy, SL072 was changed to 56 oz (1,680 ml) for code 55708 and 88 oz (2,640 ml) for code 55710. There was an issue with the 2026 inputs where the amount unit for CMS supply code *SL072 formalin* is milliliters but the inputs were based on ounces, and the ounces input recommendations where not converted to ml prior to submitting the October RUC 2024 recommendations; this issue has been corrected for the January 2026 RUC recommendations. Separately, for CPT code 55715, 35 minutes were added to ED053 *Professional PACS Workstation* and EL008 *room, MR*, based on the median physician intra-service time. For CPT Code 55705, 7 minutes were added for CA017 *Sedate/apply anesthesia* to match the other codes. Finally, CMS inquired whether CA015 *Setup scope* was required for CPT codes 55714 and 55715; however, the specialties confirmed that these two codes do not use the ultrasound probe, thus CA015 is not needed unlike the other codes in the family. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**New Technology**
CPT codes 55708, 55710, 55711 and 5XX14 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.

**Work Neutrality**
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor. The RUC did not accept compelling evidence for this code family.

**<u>Maternity Care Services (Tab 13)</u>**
**Jessica Anderson, DNP ANA), Eilean Attwood, MD (ACOG), Bradley Fox, MD (AAFP), Jon Hathaway, MD (ACOG), Lisa Hofler, MD (ACOG), Dave Holtz, MD (ACOG)**

The practice of obstetrics has transformed significantly since the maternity global codes were last valued in 2009. Over the past 15 years, the provision of maternity care has evolved in meaningful and measurable ways driven by new quality initiatives, updates in clinical practice standards and evolved patient-centered care. Today's obstetric care is characterized by a wider variety of provider models,

greater collaboration across specialties and more complex approaches to labor management designed to improve outcomes for birthing parents and neonates.

The recent maternity care services (MCS) changes provide CPT codes to capture:

- escalation of care from rural hospitals to tertiary centers;
- increasing length and complexity of labor, and increasing use of labor induction to safely reduce cesarean delivery rates;
- increasing focus on hemorrhage, cardiovascular disease, and maternal mental health to decrease key maternal morbidity and mortality;
- changes in patients and providers/practices; and
- data and information to better track care provided.

The specific CPT changes are as follows:

- Four codes revised and/or relocated to the antepartum procedures sub-section
- Four codes created to report labor management structured by initial day and subsequent day, straightforward and complex, respectively
- Two codes relocated to the labor procedures sub-section for fetal scalp blood sample and fetal monitoring consult
- Two codes created for vaginal delivery and vaginal delivery after previous c-section, one code relocated for delivery of placenta, another code relocated and revised for 1st and 2nd degree laceration repair, and two new codes for third- and fourth-degree laceration repair, respectively
- Three codes added for cesarean delivery primary, repeat, and subtotal/total hysterectomy after c-section
- One new code created for postpartum procedure uterine tamponade and relocation of an existing code for curettage, postpartum
- Deletion of 17 legacy codes
- Antepartum and postpartum care will now be reported with evaluation and management (E/M) services

The 21-code family was surveyed for the January 2026 RUC meeting. As described above, the codes were not restructured due to a request regarding misvaluation. The specialty societies proposed the coding changes for greater specificity to reflect typical practice patterns. The code family is budget neutral in its entirety; however, there are a few codes that are increasing in value and therefore, compelling evidence was presented for two of the three sub-families based on CY 2023 CDC data related to US births.[1]

**History**

The maternity care services codes, prior to this CPT code reconstruction, pre-date the inception of the Medicare Physician Payment Schedule (MFS). The last comprehensive review of maternity care services was in 2009. At that time, the valuation was based on a building block methodology, given the complexity of valuing services provided over nine full months of care. Of note, the building block methodology in the RUC database does not perfectly align with the current values due to the recent changes in E/M valuations. For example, when CMS updated the work RVUs for E/M office visits in 2021, the MCS global codes that included antepartum and postpartum visits also increased. The following history is provided below to outline the methodology used to arrive at the 2009 valuation recommendations, which CMS accepted.

[1] https://www.cdc.gov/nchs/data/databriefs/db507.pdf

The RUC utilized the following antepartum assumptions for the prior 2009 valuation of the vaginal delivery (59400), vaginal delivery after previous cesarean delivery (59610), cesarean delivery (59510), and cesarean delivery following attempted vaginal delivery after previous cesarean delivery (59618):

Antepartum Care
1-99204; time = 45 minutes; work RVU = 2.43
2-99214; time = 80 minutes (2 x 40); work RVU = 3.00 (2 x 1.50)
8-99213; time = 184 minutes (8 x 23); work RVU = 7.76 (8 x 0.97)
2-99212; time = 32 minutes (2 x 16); 0.96 (2 x 0.48)
Total time = 341 minutes; Total work RVU = 14.15
**Antepartum care will now be reported with E/M services.*

The following assumptions were used for the management of labor for the previous valuation of the maternity care global services:

Management of Labor - Vaginal Delivery (59400)
99225; time = 52.5 minutes (75 x 0.70); work RVU = 1.80
**0.70 (a proxy for the amount of face-to-face time of this service)*
1-99356; time = 60 minutes; work RVU = 1.71
3-99357; time = 90 minutes (3 x 30); work RVU = 5.13 (1.71 x 3)
Total time = 202.5 minutes; Total work RVU = 8.64

Management of Labor - Vaginal Delivery After Previous Cesarean Delivery (59610), Cesarean Delivery (59510), and Cesarean Delivery Following Attempted Vaginal Delivery After Previous Cesarean Delivery (59618)
1-99225; time = 52.5 minutes; work RVU = 1.80
1-99356; time = 60 minutes; work RVU = 1.71
4-99357; time =120 minutes (4 x 30); work RVU = 6.84 (1.71 x 4)
Total time = 232.5 minutes; Total work RVU = 10.35
**Labor Management will now be reported with CPT codes 59080-59083.*

The assumptions below were used for delivery in the previous valuation of the maternity care global services. At the time of the 2009 valuation, when a laceration occurred or an episiotomy was performed, 1st or 2nd degree repairs were included in the assumptions for the vaginal delivery codes. The same is true for the newly revised code set.

Delivery - Vaginal Delivery (59400) and Vaginal Delivery After Previous Cesarean Delivery (59610)
Intensity = 0.0224; time = 10 minutes; work RVU = 0.224
Intensity = 0.0082; time = 5 minutes; work RVU = 0.0405
Intensity = 0.104; time = 45 minutes work RVU = 4.68
Intensity = 0.0224; time = 35 minutes; work RVU = 0.784
Total time = 95 minutes; Total work RVU = 5.73
**Vaginal delivery will now be reported with CPT code 59431.*
**Vaginal delivery after previous cesarean delivery will now be reported with CPT code 59432.*

Delivery – Cesarean Delivery (59510)
Intensity = 0.0224; time = 10 minutes; work RVU = 0.224
Intensity = 0.0082; time = 10 minutes; work RVU = 0.081
Intensity = 0.104; time = 45 minutes work RVU = 4.68
Intensity = 0.0224; time = 35 minutes; work RVU = 0.784

Total time = 100 minutes; Total work RVU = 5.77
**Cesarean delivery will now be reported with CPT codes 59502(primary) and 59503 (repeat).*

Delivery – Cesarean Delivery Following Attempted Vaginal Delivery After Previous Cesarean Delivery (59618)
Intensity = 0.0224; time = 10 minutes; work RVU = 0.224
Intensity = 0.0082; time = 10 minutes; work RVU = 0.081
Intensity = 0.104; time = 50 minutes work RVU = 5.20
Intensity = 0.0224; time = 35 minutes; work RVU = 0.784
Total time = 105 minutes; Total work RVU = 6.29
**Cesarean delivery after previous cesarean delivery will now be reported with CPT code 59503.*

The following assumptions were used for postpartum care for the previous valuation of the maternity care global services:

Postpartum Care – Vaginal Delivery (59400) and Vaginal Delivery After Previous Cesarean Delivery (59610),
1-99232; time = 40 minutes; work RVU = 1.39
1-99238; time = 38 minutes; work RVU = 1.28
1-99214; time = 40 minutes; work RVU = 1.50
Total time = 118 minutes; work RVU = 4.17
**Postpartum care will now be reported with E/M services.*

Postpartum Care – Cesarean Delivery (59510), and Cesarean Delivery Following Attempted Vaginal Delivery After Previous Cesarean Delivery (59618)
1-99232; time = 40 minutes; work RVU = 1.39
1-99231; time = 20 minutes; work RVU = 0.76
1-99238; time = 38 minutes; work RVU = 1.28
1-99213; time = 23 minutes; work RVU = 0.97
1-99214; time = 40 minutes; work RVU = 1.50
Total time = 161 minutes; work RVU = 5.90
**Postpartum care will now be reported with E/M services.*

**Antepartum Care**

Antepartum care includes the management of pregnancy prior to the onset of labor. Antepartum care visits will now be reported with separately reported Evaluation & Management (E/M) services following the recommended unbundling of the CMS MMM maternity care global periods under the new code structure. The antepartum and fetal invasive procedures reviewed by the RUC in January 2026 may be separately reported from antepartum E/M visits. The budget neutrality calculations include the current antepartum care plan E/M assumptions; however, the American College of Obstetricians and Gynecologists (ACOG) has released new guidance as of April 2025 that suggests a more tailored antepartum care plan between the patient and physician/qualified health care professional (QHP) may result in fewer antepartum visits.[2] This also underscores the importance of the requested coding changes to specify reporting for antepartum care.

*Compelling Evidence – 59320*
The specialty societies presented compelling evidence that the relative value for CPT Code 59320 is inappropriately valued based on documentation in the peer-reviewed medical literature that there have

[2] https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2025/04/tailored-prenatal-care-delivery-for-pregnant-individuals

been changes in physician work due to a change in patient population. The use of cervical cerclage placement during pregnancy has seen a substantial change in patient population in recent years following the introduction of cervical length screening via ultrasound. A plurality of cervical cerclages are now placed for rescue indications based on ultrasound findings; previously, half of all cervical cerclages were placed for history-only indications. A 2024 study by Rawashdeh and Ramachandran (et. al.) published in the International Journal of Women's Health noted that history-indicated cerclage placement decreased from 50% to 30% following the introduction of cervical length screening, with rescue cerclage now being the observed indication 64% of the time.[3] Rescue cerclage placement is considered more technically challenging due to a shortened total cervical length and occurs at a later fetal gestational age. Consequently, the cerclage placed in a later gestation is also more technically challenging to remove, as there is likely to be only a thin residual cervix and compression by the fetal head.

Regarding abdominal cerclage, 2023 recommendations from the Society of Maternal Fetal Medicine note that "transabdominal cerclage placement be offered to patients with a previous transvaginal cerclage placement (history or ultrasound indicated) and subsequent spontaneous singleton delivery before 28 weeks of gestation" and therefore are associated with higher complexity of patients and a more technically challenging procedure due to anticipated scarring or changes in typical anatomy from historical procedures.[4] **The RUC accepted compelling evidence based on a change in physician work due to a change in patient population.**

*Compelling Evidence – 59412*
The specialty societies presented compelling evidence that the relative value for CPT code 59412 is inappropriately valued based on documentation and peer-reviewed medical literature that there has been a change in physician work due to change in technique. In accordance with the 2020 guidance document from ACOG, neuraxial analgesia and uterine tocolysis are now recommended to increase the rate of successful external cephalic version. The addition of these interventions allows for a more intense attempt at cephalic version secondary to improved pain control and uterine relaxation. These interventions are now considered typical, increasing the overall success and intensity of the procedure.[5] **The RUC accepted compelling evidence based on a change in physician work due to a change in technique.**

*Intensity Rank Order – Antepartum Procedures*
For the antepartum maternity care family, CPT code 59320 describes a vaginal cerclage surgical procedure under neuraxial anesthesia and requires pre and post procedural fetal observation. This purse-string suture is carefully placed around the cervix, at the junction of the lower uterine segment and the cervix. This procedure is intended to prevent premature birth or miscarriage from cervical insufficiency. Within the antepartum procedures code family, this is the lowest intensity service.

CPT code 59871 describes the surgical removal of a vaginal cerclage under neuraxial anesthesia and similarly requires pre and post procedural fetal observation of a viable fetus. This procedure is typically performed during the late preterm or early term gestation. This removal procedure, which requires anesthesia, is technically difficult due to the surrounding anatomy and the stage of gestation. Within the antepartum procedures code family, this is the second-lowest intensity service.

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[3] Rawashdeh H, Ramachandran A, Yang JM, Blain G, Hyett J. Changing Indications for Cervical Cerclage Following the Introduction of Routine Ultrasound Surveillance of Cervical Length for Prediction and Prevention of Preterm Birth. Int J Womens Health. 2024;16:1755-1764. Published 2024 Oct 26. doi:10.2147/IJWH.S477974

[4] Temming L, Mikhail E. Society for Maternal-Fetal Medicine Consult Series #65: Transabdominal cerclage. *Am J Obstet Gynecol*. 2023;228(6):B2–B10. doi:10.1016/j.ajog.2023.02.018

[5] External Cephalic Version: ACOG Practice Bulletin, Number 221. Obstet Gynecol. 2020;135(5):e203-e212. doi:10.1097/AOG.0000000000003837

CPT code 59325 describes an abdominal cerclage, which is recommended for placement in the case that a vaginal cerclage has already failed or a patient has a history of a previously failed vaginal cerclage. This is an open abdominal procedure during pregnancy that poses an increased risk to the fetus and the possibility of increased bleeding that could incite pre-term labor. This procedure is performed to maintain the pregnancy to term or near term. This is typically a planned procedure after a routine ultrasound where the vaginal cerclage has failed. Within the antepartum procedures code family, this is the second highest intensity service.

CPT code 59412 describes external cephalic version to turn the fetus during the later preterm or early term gestation under neuraxial anesthesia with uterine tocolysis. This procedure poses an increased risk to the fetus including fetal heart rate abnormalities and abruptio placenta leading to unintended emergent delivery. Pre- and post-procedural fetal observation of a viable fetus is required. This is the highest intensity service within the antepartum procedure code family.

**59320** ***Cerclage of cervix, during pregnancy; vaginal***
The RUC reviewed the survey results from 207 obstetricians, gynecologists, and family physicians and recommends a work RVU of 3.02 based on a direct work RVU crosswalk to CPT code 19083 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance* (work RVU = 3.02 and 25 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 33 minutes of pre-service evaluation time, 8 minutes positioning time, 10 minutes scrub/dress/wait time, 25 minutes intra-service time, and 20 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to the first key reference service 57461 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix* (work RVU = 3.34 and 28 minutes intra-service time). The surveyed code has more total time when compared to the key reference service, however, the key reference service is more intense/complex to perform suggesting that the surveyed code is valued appropriately lower.

For additional support, the RUC compared the surveyed code to CPT codes 43195 *Esophagoscopy, rigid, transoral; with balloon dilation* (less than 30 mm diameter) (work RVU = 2.99 and 30 minutes intra-service time) and 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy;* (work RVU = 3.03 and 30 minutes intra-service time). Both reference codes have more intra-service time, although slightly lower total time, suggesting that the surveyed code should be valued similarly. The RUC noted that a database search of codes with similar work RVUs, intra-service time, and total time suggested that this recommended work RVU is relative within the MFS. **The RUC recommends a work RVU of 3.02 for CPT code 59320.**

**59325** ***Cerclage of cervix, during pregnancy; abdominal***
The RUC reviewed the survey results from 102 obstetricians, gynecologists, and family physicians and recommends a work RVU of 6.34 based on a direct work RVU crosswalk to CPT code 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* (work RVU = 6.34 and 60 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 33 minutes of pre-service evaluation time, 8 minutes positioning time, 10 minutes scrub/dress/wait time, 60 minutes intra-service time, and 20 minutes immediate post-service time. These patients are coming in for a scheduled procedure. It is not anticipated that an E/M service will be reported on the same day.

To support the recommended work RVU, the RUC compared the surveyed code to MPC codes 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU = 5.30 and 45 minutes of intra-service time) and 37212 *Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day* (work RVU = 6.64 and 60 minutes intra-service time). The reference MPC codes appropriately bracket the surveyed code work RVU and intensity/complexity to perform the service. The surveyed code has identical intra-service time when compared to the second MPC code, although the surveyed code requires more total time than both reference codes. The recommended work RVU supports relativity in comparison to the MPC codes.

For additional support, the RUC referenced CPT code 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 6.39 and 60 minutes intra-service time). The surveyed code and reference CPT code have identical intra-service time while the reference code has more total time, the surveyed code is more intense/complex to perform supporting the recommended work RVU. **The RUC recommends a work RVU of 6.34 for CPT code 59325.**

**59412** ***External cephalic version***
The RUC reviewed the survey results from 334 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 2.63 based on a direct work RVU crosswalk to CPT code 31295 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa* (work RVU = 2.63 and 20 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 12 minutes of pre-service evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, and 20 minutes immediate post-service time. It is important to note that the language "with or without tocolysis" was included in the previous CPT descriptor and removed during the revision of this code family, given it is not a procedure per se, but a medication administered during the procedure. ACOG practice guidance now states that tocolysis is typically part of the procedure as described in the compelling evidence discussion for this code.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 2.75 and 25 minutes intra-service time). The surveyed code has less intraservice time and slightly less total time, suggesting that the recommended work RVU for the surveyed code is appropriately below the MPC reference code. For additional support, the RUC referenced CPT code 51102 (work RVU = 2.63 and 20 minutes intra-service time) and 43249 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)* (work RVU = 2.60 and 20 minutes intra-service time). The surveyed code and reference CPT codes have identical intra-service time, similar total time, and are relatively similar in the intensity/complexity to perform, suggesting that the codes should be valued similarly. **The RUC recommends a work RVU of 2.63 for CPT code 59412.**

**59871** ***Removal of cerclage suture under anesthesia (other than local)***
The RUC reviewed the survey results from 290 obstetricians, gynecologists, and family physicians and recommends a work RVU of 2.15 based on a direct work RVU crosswalk to CPT code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 2.15 and 15 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 25 minutes of pre-

service evaluation time, 8 minutes positioning time, 9 minutes scrub/dress/wait time, 15 minutes intra-service time, and 15 minutes immediate post-service time.

To support the recommended work RVU, the RUC compared the surveyed code to the first key reference service code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU = 2.27 and 20 minutes intra-service time). The surveyed code has less intra-service time and more total time when compared to the key reference service, although the reference code is more intense/complex to perform. The recommended work RVU is appropriately relative to the first key reference service.

For additional support, the RUC referenced CPT code 31577 *Laryngoscopy, flexible; with removal of foreign body(s)* (work RVU = 2.14 and 15 minutes intra-service time). While the surveyed code and MPC code have identical intra-service time, the surveyed code is less intense/complex to perform, and it has significantly more total time, suggesting that the recommended work RVU is appropriately supported based on similarly valued services. **The RUC recommends a work RVU of 2.15 for CPT code 59871.**

**Labor Management & Delivery**

*Budget Neutrality & National Estimates*
The budget neutrality calculations were computed based on current bundle assumptions utilizing CY 2023 CDC data related to US births. The labor and delivery code set is budget neutral and does not require compelling evidence.

Approximately 3.5 million births occur annually in US in hospitals.[6] Over 50% (50-70%) of US annual births are to primipara (i.e., women who are giving birth for the first time) and about 35% of all births will be induced with most of those being in primiparas.[7] Labor inductions are generally scheduled to begin with admissions throughout the day, but usually not before 6 am. Typically, inductions will take an average of 24 hours, suggesting that inductions will have 2 days of labor management. Primiparas who go into spontaneous labor may present to the hospital at any time of the day, and it is anticipated that one-third of those will go past midnight. Based on this, it is anticipated that slightly more than half of total cases will pass midnight and have 2 days of labor management, and those that reach 3 days of labor are rare. About 30-35% of all US births are cesarean deliveries and of those, one third are repeat cesareans. It is understood that only 15% of women who had a previous cesarean delivery will attempt a vaginal birth after cesarean (i.e., VBAC).[8] Further, the CPT introductory guidelines state that a repeat cesarean delivery (59503) is typically a planned event without labor management. It is anticipated that most deliveries will be reported with vaginal delivery CPT code 59431 (~65%), followed by primary cesarean sections 59502 (20%), then repeat cesarean sections 59503 (10%) and then VBAC 59432 (5%).

Further, the typical US hospital averages fewer than 3 births/day. A recent JAMA article looked at the birth volume and geographic distribution of US hospitals with obstetric services from 2010 to 2018 and found 58.9% of hospitals had fewer than 1000 births per year.[9] The largest group of obstetric hospitals in the US (37.4%) was low volume (0-500 births per year) and 21.5% had 501-1000 births per year. These data are in line with the leading medical professional liability program,

[6] https://www.cdc.gov/nchs/data/databriefs/db507.pdf
[7] https://evidencebasedbirth.com/arrive/#:~:text=Inductions%20of%20labor%20have%20become,2018
[8] https://www.cdc.gov/nchs/nvss/births.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fnchs%2Fbirths.htm
[9] Handley SC, Passarella M, Herrick HM, Interrante JD, Lorch SA, Kozhimannil KB, Phibbs CS, Foglia EE. Birth Volume and Geographic Distribution of US Hospitals With Obstetric Services From 2010 to 2018. JAMA Netw Open. 2021 Oct 1;4(10):e2125373. doi: 10.1001/jamanetworkopen.2021.25373. PMID: 34623408; PMCID: PMC8501399.

CRICO, *Clinical Guidelines for Obstetrical Services* which state a single provider should not exceed 3 low-risk patients in active labor after which additional help should be readily available.[10]

Following the CRICO guidelines that recommend a single provider should not exceed more than 3 low-risk patients (59080/59431), including one of the three as a high risk (59081/59502) (for illustrative purposes) and accounting for three additional patients laboring, but not in active labor, the survey results come in below the number of minutes in a day. ACOG recommends that cervical dilation of 6 cm be considered the start of the active phase of labor.[11] The survey results align with national estimates and typical hospital volumes for labor and delivery.

*Labor Management and Delivery RUC Surveys*
The new labor management and delivery codes were surveyed by a combination of members from ACOG, the American Nurses Association (ANA), the American College of Nurse Midwives (ACNM), and an approved subset of the American Academy of Family Physicians (AAFP). The survey had strong total response numbers, with the highest response number of combined responses from all three specialties, being 671. Consistent with national obstetric data, the overwhelming majority of these responses were from the American College of Obstetricians and Gynecologists for all codes surveyed.

*High Intensity*
The specialty societies stated that the maternity care services codes were surveyed and presented at the October 2009 RUC meeting after they were identified as potentially misvalued due to high IWPUTs. The RUC maintained the high IWPUTs in their October 2009 recommendations to CMS, which CMS subsequently accepted. During the January 2026 RUC meeting, the specialty societies noted that the IWPUTs remain high in the labor and delivery code family, given the unique nature of the services. Labor and delivery services are a unique type of care provided for two patients whose conditions are tightly linked requiring interpretation of two sets of data and their interdependencies in real time. In addition, management decisions for one patient directly impact the well-being of the other patient and obstetric emergencies can arise quickly in either or both patients and require immediate intervention that may or may not be different for each patient. The RUC determined that high IWPUTs are appropriate given the typical provider is concurrently caring for two patients, which significantly increases psychological stress as the adverse outcomes during labor and/or delivery have serious consequences that increase chances of morbidity and/or mortality of the parturient (i.e., pregnant person who is in labor or preparing for birth) and fetus. **The RUC agreed that the high IWPUT for the labor and delivery services remains appropriate given the unique nature of these services, where the provider is concurrently caring for two patients.**

<u>Labor Management</u>

*Survey – Data Trimming*
For the newly created labor management codes, the specialties observed that some survey participants were likely challenged by the time estimate questions, despite the CPT guidelines being included with the survey. For example, a small subset of survey respondents included times equal to 1,400 minutes (approximately 24 hours x 60 minutes).

[10] CRICO. Clinical Guidelines for Obstetrical Services at CRICO-insured Institutions. Boston, MA: CRICO; 2022. Available at: https://www.rmf.harvard.edu/guidesob.
[11] ACOG. First and Second Stage Labor Management. Clinical Practice Guideline No. 8. Available at: https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2024/01/first-and-second-stage-labor-management

For this reason, the specialty societies reviewed the available historical information from the RUC Research Subcommittee related to data trimming. In the available information, it was stated that minimal trimming was utilized during the previous analysis of large survey data sets. Specifically, for the Socioeconomic Monitoring Survey (SMS), records were eliminated above and below three standard deviations. At the time, AMA economists recommended that no standard data trimming be used on RUC surveys, given that the RUC reviews data points primarily set at the median value. Since RUC surveys are typically based on relatively low sample sizes, trimming based on a standard deviation is unlikely to remove records. The Research Subcommittee's policy states any data trimming should be reviewed on a code-by-code basis, rather than systematically.

Based on the AMA's positions on data trimming and the number of labor management survey results, the specialty societies ran two data sets, one with all the data and one that removed the data three standard deviations from the mean. There were minor data set differences that applied only to CPT codes 59081 and 59083. Both data sets are reflected in the summary spreadsheet. **The RUC agreed with applying data trimming to labor management which minimally impacted the work or intra-time for CPT codes 59081 and 59083 only.**

*Code Structure*
Labor management involves integrated decision making to assess, support, and balance the well-being of the parturient (ie, pregnant person who is in labor or preparing for birth) and fetus(es), including managing medical conditions or complications (eg, cardiac or neurological conditions, diabetes, hypertension, preeclampsia, abnormal fetal heart tracings, labor dystocia). The goal of labor management is optimizing parturient and fetal well-being to achieve the delivery of the fetus(es). Please see the Labor Management CPT introductory guidelines for additional clinical and coding instruction. Labor management is similar to existing Evaluation and Management (E/M) codes: the work of labor management is in evaluating and treating medical conditions or complications in addition to managing the labor itself, ordering and/or interpreting diagnostic tests/studies (eg, fetal heart tracings), and managing high-risk medications such as those used for induction of labor.

Labor complexity consists of two levels of labor management: straightforward (59080, 59082) and complex (59081, 59083). For reporting purposes, the level of labor management is based on the condition of the parturient and fetus(es) and the complexity of medically necessary medical decision making (MDM) and associated services. The duration of labor does not indicate the complexity of labor management, unless prolonged labor is diagnosed. The highest level of labor management performed is reported once per calendar date. For example, if labor management begins as straightforward and transitions to complex labor management during the same calendar date, report only complex labor management for that calendar date. Straightforward and complex labor management are classified as follows:

Straightforward:

- If all the following are not met, refer to complex labor management:
    - Singleton vertex presentation
    - Routine maternal/fetal monitoring
    - Fetal monitoring (eg, heart rate) not requiring physician or other QHP intervention
    - Normal progression of labor or routine labor induction or augmentation
    - Stable medical conditions (eg, well-controlled hypertension, diet-controlled diabetes) not requiring additional management during labor
    - No previous cesarean delivery

Complex:

- Any labor management that is not explicitly defined as straightforward in this table:
    - More than one fetus
    - Fetal monitoring (eg, heart rate) abnormalities requiring change in management requiring physician or other QHP intervention
    - Prolonged first or second stage of labor
    - Labor complications (eg, intraamniotic infection and/or inflammation, preeclampsia)
    - One or more severe maternal morbidity indicator(s) (eg, acute renal failure, eclampsia)
    - Maternal medical conditions (eg, hypertension, diabetes, morbid obesity) requiring additional medical management during labor
    - Previous cesarean delivery

**59080** ***Initial day labor management; straightforward, per day***
The RUC reviewed the survey results from 656 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 3.50 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 80 minutes of intra-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during labor have serious consequences that increase chances of morbidity and/or mortality of the parturient and fetus/neonate.

To support the recommended work RVU, the RUC compared the surveyed code to the key reference service MPC code 99223 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.* (work RVU = 3.50 and 74 minutes intra-service time). The surveyed code recommended work RVU is appropriately aligned with the key reference service 99233.

For additional support, the RUC compared the surveyed code to MPC code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.* (work RVU = 3.50 and 59 minutes intra-service time) and 99306 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.* (work RVU = 3.50 and 50 minutes intra-service time). The surveyed code recommended work RVU is appropriately aligned with the MPC reference codes, given the similar total time. **The RUC recommends a work RVU of 3.50 for CPT code 59080.**

**59081** ***Initial day labor management; complex, per day***
The RUC reviewed the survey results from 641 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 4.50 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 120 minutes of intra-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during labor have serious consequences that increase chances of morbidity and/or mortality of the parturient and fetus/neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service code 99236 *Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.* (work RVU = 4.30 and 85 minutes intra-service time). The surveyed code recommended work RVU is appropriately higher than the key reference service due to the higher total time required.

For additional support, the RUC compared the surveyed code to CPT code 93355 *Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D* (work RVU = 4.54 and 120 minutes of intra-service time). While the surveyed code and reference code have identical intra-service time, the reference code has more total time, and the surveyed code is more intense/complex to perform, suggesting that the codes should be valued similarly given these comparisons. **The RUC recommends a work RVU of 4.50 for CPT code 59081.**

**59082 *Subsequent day labor management; straightforward, per day***
The RUC reviewed the survey results from 655 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 3.00 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 75 minutes of intra-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during labor have serious consequences that increase chances of morbidity and/or mortality of the parturient and fetus/neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service code 99233 *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.* (work RVU = 2.40 and 52 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported, given that the surveyed code has significantly more intra-service and total time when compared to the key reference service.

For additional support, the RUC compared the surveyed code to MPC codes 99222 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.* (work RVU = 2.60 and 55 minutes intra-service time) and 99223 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.* (work RVU = 3.50 and 74 minutes of intra-service time). They surveyed code work RVU is appropriately bracketed by the reference codes. **The RUC recommends a work RVU of 3.00 for CPT code 59082.**

**59083** ***Subsequent day labor management; complex, per day***
The RUC reviewed the survey results from 642 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 4.20 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 115 minutes of intra-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during labor have serious consequences that increase chances of morbidity and/or mortality of the parturient and fetus/neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service code 99236 *Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.* (work RVU = 4.30 and 85 minutes intra-service time). The surveyed code recommended work RVU is appropriately aligned with the work of 99236.

For additional support, the RUC compared the surveyed code to CPT code 77338 *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan* (work RVU = 4.18 and 115 intra-service time). The surveyed code and reference code have identical intra-service and total time, suggesting that the codes should be valued similarly. **The RUC recommends a work RVU of 4.20 for CPT code 59083.**

Vaginal Delivery

**59431** ***Vaginal delivery, with or without episiotomy;***
The RUC reviewed the survey results from 480 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 8.00 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this code. The RUC recommends 7 minutes pre-service positioning time, 5 minutes scrub/dress/wait time, 40 minutes intra-service time, and 20 minutes immediate post-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during delivery have serious consequences that increase chances of morbidity and/or mortality of the parturient and neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 49593 *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, reducible* (work RVU = 10.00 and 90 minutes intra-service time) and 58561 *Hysteroscopy, surgical; with removal of leiomyomata* (work RVU = 6.44 and 45 minutes intra-service time). The surveyed code recommended work RVU is appropriately bracketed by the key reference services, given that the surveyed code is much more intense/complex compared to the key reference services, despite having lower intra-service and total time.

For additional support, the RUC compared the surveyed code to CPT code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 7.36 and 45 minutes intra-service time). The surveyed code is much more intense/complex to perform when compared to the reference code, even though

the reference requires more intra-service and total time. **The RUC recommends a work RVU of 8.00 for CPT code 59431.**

**59432** ***Vaginal delivery, with or without episiotomy; after previous cesarean delivery***
The RUC reviewed the survey results from 472 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 9.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 8 minutes pre-service positioning time, 5 minutes scrub/dress/wait time, 45 minutes intra-service time, and 20 minutes immediate post-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during delivery have serious consequences that increase chances of morbidity and/or mortality of the parturient and neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service 58561 *Hysteroscopy, surgical; with removal of leiomyomata* (work RVU = 6.44 and 45 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported by the key reference service, given that the surveyed code is much more intense/complex compared to the key reference service, despite having identical intra-service time.

For additional support, the RUC compared the surveyed code to CPT code 92920 *Percutaneous transluminal coronary angioplasty, single major coronary artery and/or its branch(es)* (work RVU = 8.14 and 48 minutes intra-service time). The surveyed code is much more intense/complex to perform when compared to the reference code, even though the reference requires more intra-service and total time. **The RUC recommends a work RVU of 9.00 for CPT code 59432.**

Cesarean Delivery

For cesarean delivery there is an extended amount of time for which the patient is positioned for surgery, and the fetus is unmonitored and fetal wellbeing in unknown following abdominal scrub. With repeat cesarean delivery this concern is even more acute as abdominal entry is increasingly complex due to the presence of significant abdominal adhesions, increasing the total time of abdominal entry to safe uterine exposure where the fetal status continues to be unknown prior to fetal delivery. Throughout this time physician physical and psychological intensity is extremely high due to the potential associated fetal adverse outcomes. Following fetal delivery, surgeon intensity remains high due to the rapid blood loss from the uterine incision and followed by required closure of multiple layers of a previously operated abdomen.

**59502** ***Cesarean delivery; primary***
The RUC reviewed the survey results from 469 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 12.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 23 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes scrub/dress/wait time, 51 minutes intra-service time, and 20 minutes immediate post-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during delivery have serious consequences that increase chances of morbidity and/or mortality of the parturient and neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 49616 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated* (work RVU = 15.16 and 140 minutes intra-service time) and 49615 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible* (work RVU = 11.17 and 100 minutes intra-service time). The surveyed code recommended work RVU is appropriately bracketed by the key reference services, given that the surveyed code is significantly more intense/complex compared to the key reference services, despite having lower intra-service and total time.

For additional support, the RUC compared the surveyed code to CPT codes 93582 *Percutaneous transcatheter closure of patent ductus arteriosus* (work RVU = 12.00 and 60 minutes intra-service time) and 92941 *Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single major coronary artery and/or its branches or single bypass graft and/or its subtended branches* (work RVU = 12.40 and 65 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported by the reference codes, given that the surveyed code is significantly more intense/complex compared to the reference codes, despite having lower intra-service and total time. **The RUC recommends a work RVU of 12.00 for CPT code 59502.**

**59503 *Cesarean delivery; repeat***
The RUC reviewed the survey results from 468 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 14.66 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this code. The RUC recommends 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes scrub/dress/wait time, 65 minutes intra-service time, and 20 minutes immediate post-service time. The RUC determined that the high IWPUT for this service is appropriate given that the typical provider is concurrently caring for two patients whose conditions are tightly linked, which significantly increases psychological stress as the adverse outcomes during delivery have serious consequences that increase chances of morbidity and/or mortality of the parturient and neonate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 49616 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated* (work RVU = 15.16 and 140 minutes intra-service time) and 49615 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible* (work RVU = 11.17 and 100 minutes intra-service time). The surveyed code recommended work RVU is appropriately bracketed by the key reference services, given that the surveyed code is significantly more intense/complex compared to the key reference services, despite having lower intra-service and total time.

For additional support, the RUC compared the surveyed code to 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or*

*lymphatic extravasation* (work RVU = 13.41 and 90 minutes intra-service time). The surveyed code recommended work RVU is appropriately higher compared to the reference MPC code, given that the surveyed code is significantly more intense/complex to perform despite having lower intra-service and total time. The RUC also referenced CPT code 33741 *Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)* (work RVU = 13.65 and 55 minutes intra-service time). The surveyed code is valued appropriately higher given the higher intra-service time, lower total time, and similar intensity/complexity to perform the service when compared to the reference code. **The RUC recommends a work RVU of 14.66 for CPT code 59503.**

**Labor Procedures, Other Delivery Procedures, and Postpartum Care**

*Compelling Evidence – 59051*
The specialty societies presented compelling evidence that the relative value for CPT code 59051 is inappropriately valued, based on documentation in the peer-reviewed medical literature that there have been changes in physician work due to a change in technique. Specialty society clinical guidance for fetal evaluation during labor drastically changed in 2010 when a new structure and nomenclature was introduced in guidance published by the American College of Obstetricians and Gynecologists specific to the management of labor, including the definitions of Category 1, 2, and 3 fetal heart tracings.[12] This now stands in contrast to what was previously used during labor and continues to be used today for antepartum fetal testing. Previous nomenclature included only "reassuring" and "non-reassuring" and had little nuance in its definition and interpretation. Current guidance has significantly more detail, acknowledging the challenging considerations required for Category 2 fetal heart tracings, which are the typical patient described by this code. Management for Category 2 tracings "require[s] evaluation, continued surveillance, initiation of appropriate corrective measures when indicated, and reevaluation. Once identified, these tracings may require more frequent evaluation, documentation, and continued surveillance." **The RUC accepted compelling evidence based on a change in physician work due to a change in technique.**

*Compelling Evidence – 59160*
The specialty societies presented compelling evidence that the relative value for CPT Code 59160 is inappropriately valued, based on documentation in the peer-reviewed medical literature that there have been changes in physician work due to a change in technique. Prior practice for postpartum curettage involved using a large, sharp banjo curette to slowly remove small pieces of retained products of conception in the setting of postpartum hemorrhage thought to be caused by retained products only. This procedure was often done at bedside and with limited ability to remove other blood product or clots accumulating within the uterus during an acute hemorrhage event. Sharp curettage is associated with increased risk of uterine scarring with concerns for subsequent impact on fertility. Current typical practice for acute hemorrhage requiring postpartum curettage now involves urgent transfer to the operating room and use of a suction curettage device and intraoperative ultrasound guidance. Suction curettage allows more efficient removal of both retained products of conception and any blood or clots accumulating in the uterus while minimizing the potential for uterine scarring. This current technique efficiently and safely manages multiple potential causes that may be inhibiting adequate uterine contraction to mitigate continued acute hemorrhage of the

[12] Management of intrapartum fetal heart rate tracings. Practice Bulletin No. 116. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:1232–40.

postpartum patient.[13] **The RUC accepted compelling evidence based on a change in physician work due to a change in technique.**

Labor Procedures

**59030** ***Fetal scalp blood sampling***
The RUC reviewed the survey results from 113 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 0.90 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 7 minutes pre-service evaluation time, 12 minutes intra-service time, and 5 minutes immediate post-service time. This code was changed from a 000-day global period to an XXX global period. The specialties and RUC agreed that it is similar to fetal monitoring and is performed only during active labor. This procedure, while rare, is typically done by the same physician or QHP who is performing the labor management.

To support the recommended work RVU, the RUC compared the surveyed code to MPC codes *74246 Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.88 and 15 minutes intra-service 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 and 15 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported by the reference MPC codes, given the similar intra-service and total time of the services. Specifically, the surveyed code is similar in intensity/complexity to MPC code 99202 given that the surveyed code describes a new procedure for the patient during the labor course and is specifically associated with unique counseling and consent, similar to what would be expected when caring for a new patient encounter. **The RUC recommends a work RVU of 0.90 for CPT code 59030.**

**59051** ***Fetal monitoring during labor by consulting physician (ie, non-attending physician) or other qualified health care professional, with interpretation and report***
The RUC reviewed the survey results from 372 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 0.93 based on a direct work RVU crosswalk to CPT code 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 and 15 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 8 minutes pre-service evaluation time, 15 minutes intra-service time, and 5 minutes immediate post-service time.

In current practice this code is not typically reported together with an E/M service and is not anticipated to be performed with an E/M service moving forward. The CPT code descriptor was updated by the specialty societies in accordance with the CPT Editorial Panel to be more prescriptive, and nothing precludes it from being performed with an E/M service; that said, if an E/M service were needed, it would be based on medical necessity. Further, the instructional parenthetical under deleted code 59050 states, "For interpretation and report of fetal heart tracing, use 59051. If a consultation is requested for parturient or fetal well-being other than fetal heart monitoring, see the appropriate E/M

[13] Nir A, Mor M, Yekutiel M, Eisenberg N, Smorgick N. Postpartum retained products of conception: Is it possible to avoid postpartum curettage?. Int J Gynaecol Obstet. 2022;156(2):231-235. doi:10.1002/ijgo.13696

codes." The surveyed code is a moderate intensity cognitive-based code that requires assessment by another physician/QHP for real-time recommendations of an abnormal fetal heart tracing. Following review of the tracing, recommendations to either continue the labor course or consider expeditious delivery are given to the primary obstetric team. The surveyed code is similar in intensity to MPC code 99232 *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.* (work RVU = 1.59 and 36 minutes intra-service time).

For additional support, the RUC compared the surveyed code to MPC codes 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.88 and 15 minutes intra-service time) and 36440 *Push transfusion, blood, 2 years or younger* (work RVU = 1.00 and 15 minutes intra-service time). The surveyed code intra-service time is identical to the MPC reference codes, and the surveyed code total time is bracketed by both MPC codes, suggesting that the recommended work RVU is appropriately relative and therefore supported. **The RUC recommends a work RVU of 0.93 for CPT code 59051.**

Other Delivery Procedures

**59414** ***Delivery of placenta only (separate procedure)***
The RUC reviewed the survey results from 460 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 1.61 based on the current value, which maintains relativity within the family for this code. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, and 12 minutes immediate post-service time.

The prolonged third stage of labor is defined as greater than 30 minutes from delivery of the infant to delivery of the placenta. The risk of complications, including hemorrhage, increases significantly after 30 minutes without delivery of the placenta. Specialty society guidance recommends active management of the third stage of labor, including the routine use of uterotonic medications to minimize the potential for postpartum hemorrhage. Uterotonics should be given throughout the third stage of labor and following the delivery of the placenta. With prolonged third stage of labor, considerations of additional medications such as antibiotics or other medications such as antifibrinolytics are often required for infection prevention and bleeding management. The CPT guidelines state that for vaginal deliveries, delivery of placenta (59414) is reported when performed by a physician or other QHP who did not perform the vaginal delivery.

To support the recommended work RVU, the RUC compared the surveyed code to CPT codes 20220 *Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)* (work RVU = 1.61 and 20 minutes intra-service time) and 47000 *Biopsy of liver, needle; percutaneous* (work RVU = 1.61 and 20 minutes intra-service time). The surveyed code has identical intra-service time and similar total time when compared to the reference CPT codes, suggesting that the surveyed code should be valued similarly. **The RUC recommends a work RVU of 1.61 for CPT code 59414.**

**59300** ***Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)***
The RUC reviewed the survey results from 444 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 1.76 based on a direct work RVU

crosswalk to CPT code 36514 *Therapeutic apheresis; for plasma pheresis* (work RVU = 1.76 and 20 minutes-intra-service time), which maintains relativity within the family for this code. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, and 10 minutes immediate post-service time.

The CPT guidelines state that first- or second-degree episiotomy or laceration (tear) repair is included in the vaginal delivery codes (59431, 59432). Repair of a first- or second-degree laceration or episiotomy performed by a physician or other QHP not performing the vaginal delivery may be reported with 59300. Further, this is a moderate complexity procedure requiring the physician to evaluate the patient and the current vaginal laceration following the infant and placental delivery. This laceration is assessed to be a first or second-degree laceration, which typically involves repair of multiple tissue layers, including the vaginal mucosa and underlying submucosal tissue.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU = 1.77 and 20 minutes intra-service time) and 50435 *Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation* (work RVU = 1.77 and 20 minutes intra-service time). The surveyed code has identical intra-service time and similar total time when compared to the reference CPT codes, suggesting that the surveyed code should be valued similarly. **The RUC recommends a work RVU of 1.76 for CPT code 59300.**

**59433 *Repair of episiotomy or laceration; third-degree laceration***
The RUC reviewed the survey results from 471 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 2.47 based on a direct work RVU crosswalk to CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.47 and 30 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 5 minutes pre-service evaluation time, 6 minutes pre-service positioning time, 2 minutes scrub/dress/wait time, 30 minutes intra-service time, and 15 minutes immediate post-service time. This new code is currently reported with unlisted code 59899.

The CPT guidelines state that repair of third- or fourth-degree episiotomy or laceration is not included in 59431 and 59432 and may be separately reported with 59433 or 59434. CPT Codes 59433 and 59434 will typically be reported on the same day as another 000-day global service (eg, delivery), so the multiple procedure payment reduction (MPPR) will be applied. As such, the specialty societies have included pre- and post-time recommendations based on a stand-alone service. Further, the survey for this code included a custom question inquiring whether the provider who performed the third- and fourth-degree laceration repair also performed the delivery and whether the repair was performed in the operating room. The survey showed that 98% of survey respondents personally perform the repair, 14% of whom perform the third-degree repair in the operating room.

CPT code 59433 has increased complexity compared to 59300, as this repair requires the additional evaluation and repair of the internal and/or external anal sphincters. Sphincter edges must be carefully identified and reapproximated, assessing appropriate tension and being careful not to involve the anal canal.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 2.75 and 25 minutes intra-service time). The surveyed code requires more intra-service and total time, although it is less intense/complex to perform when compared to the MPC code, suggesting that the recommended work RVU is appropriately relative and therefore supported. **The RUC recommends a work RVU of 2.47 for CPT code 59433.**

**59434** ***Repair of episiotomy or laceration; fourth-degree laceration***
The RUC reviewed the survey results from 462 obstetricians, gynecologists, family physicians, and certified nurse-midwives and recommends a work RVU of 4.14 based on a direct work RVU crosswalk to CPT code 47532 *Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)* (work RVU = 4.14 and 45 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 12 minutes pre-service evaluation time, 6 minutes pre-service positioning time, 7 minutes scrub/dress/wait time, 45 minutes intra-service time, and 16 minutes immediate post-service time. This new code is currently reported with unlisted code 59899.

The CPT guidelines state that repair of third- or fourth-degree episiotomy or laceration is not included in 59431 and 59432 and may be separately reported with 59433 or 59434. CPT Codes 59433 and 59434 will typically be reported on the same day as another 000-day global service (eg, delivery), so the MPPR will apply. As such, the specialty societies have included pre- and post-time recommendations based on a stand-alone service. The survey for this code included a custom question inquiring whether the provider who performed the third- and fourth-degree laceration repair also performed the delivery and whether the repair was performed in the operating room. The survey showed that 98% of survey respondents personally perform the repair, 60% of whom perform the fourth-degree repair in the operating room.

The third code in this series, 59434, has the greatest complexity/intensity as the rectal mucosa is disrupted. This procedure is typically done in the operating room due to needing additional analgesia and improved visualization, and requires identification and repair of the rectal mucosa, followed by repair of the internal and/or external anal sphincter, followed by repair of the overlying submucosa and vaginal mucosa in that exact order.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 43238 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)* (work RVU = 4.06 and 45 minutes intra-service time) and 43211 *Esophagoscopy, flexible, transoral; with endoscopic mucosal resection* (work RVU = 4.10 and 45 minutes intra-service time). The surveyed code has identical intra-service time, similar total time, and is much more intense/complex to perform when compared to the reference CPT codes. Therefore, the slightly higher recommended work RVU is supported. **The RUC recommends a work RVU of 4.14 for CPT code 59434.**

**59504** ***Subtotal or total hysterectomy after cesarean delivery***
The RUC reviewed the survey results from 412 obstetricians and gynecologists and recommends a work RVU of 15.56 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this code. The RUC recommends 27 minutes pre-service evaluation time, 8 minutes pre-service positioning time, 10 minutes scrub/dress/wait time, 120 minutes intra-service time, and 45 minutes immediate post-service time. This code is currently reported with CPT code 59525 and has changed

given that it could previously only be reported by the physician performing the cesarean delivery and that is not a current representation of practice patterns today.

A hysterectomy immediately following a cesarean delivery within the same operative session is typically performed by a different surgeon than the surgeon who performed the cesarean delivery. ACOG guidance states that a cesarean hysterectomy is technically challenging and should be performed by an experienced surgeon with specialized expertise. The specialty societies stated that in the rare instance when the surveyed code is performed by the delivering obstetrician, modifier 51 will account for the efficiencies in pre-service and post-service work. This guidance is included in an instructional parenthetical that accompanies the surveyed code. The specialty societies also noted that it is typical and recommended for the surgeons performing the cesarean section to remain in the room with the specialist throughout the hysterectomy who is acting as the primary surgeon. A January 2025 study found 14.6% of hysterectomies after cesareans were emergency, and the remaining are planned.[14] The recommendations for treating suspected placenta accreta spectrum (PAS) are to schedule the cesarean delivery and immediate hysterectomy between 34- and 36-weeks gestation.

The most intense of these immediate postpartum procedures is the hysterectomy following cesarean delivery (59504). As mentioned, typically this procedure is planned, however, the intensity of this code is due to the acute bleeding unresponsive to all prior management attempts and is typically associated with high-volume blood loss requiring multiple units of blood transfusion. Further, hysterectomy at the time of a cesarean section is considered one of the most intense procedures performed by obstetricians and gynecologists. At term, 20-25% of maternal blood is flowing to the uterus, between 250-500 ml/minute. The placenta has typically invaded the wall of the uterus causing distortions in vascular anatomy and involvement in surrounding organs. Practice patterns for a hysterectomy after cesarean section have changed significantly from the delivering obstetrician performing the procedure to a second specialist. With improvements in antepartum ultrasound, diagnosis of conditions that predispose to hysterectomy after cesarean delivery, such as PAS, can be made prior to delivery, allowing for referrals to specialty centers and care by multidisciplinary teams.[15] Care coordination now includes antepartum care conferences with anesthesiologists, nursing, blood bank, the delivering obstetrician, the surgeon performing the hysterectomy, and Maternal Fetal Medicine subspecialists.

To support the recommended work RVU, the RUC compared the surveyed code to key reference service codes 49616 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated* (work RVU = 15.16 and 140 minutes intra-service time) and 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU = 13.88 and 120 minutes intra-service time). The surveyed code work RVU is appropriately higher than the key reference services, given the intensity/complexity to perform a subtotal or total hysterectomy after a cesarean delivery, even though the intra-service time is identical to key reference code 11005 and the total time is lower than both reference codes.

For additional support, the RUC compared the surveyed code to MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for*

[14] Matsuo K, Matsuzaki S, Song BB, et al. Emergency cesarean hysterectomy for placenta accreta spectrum: Estimation of maternal morbidity and mortality. *Int J Gynecol Obstet*. 2025; 00: 1-4. doi:10.1002/ijgo.70307

[15] https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum

*arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.41 and 90 minutes intra-service time). The surveyed code may be considered as slightly less intense than MPC code 37244, which is also used for acute hemorrhage and patient stabilization; however, the surveyed code has 44 additional minutes of total time, including 30 minutes of additional intra-service time. MPC code 37244 is currently the highest RVU 000-day global MPC code. Therefore, the RUC also referenced 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, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry* (work RVU = 14.63 and 120 minutes intra-service time). The surveyed code has identical intra-service time, slightly more total time, and is more intense/complex to perform when compared to the reference CPT code, suggesting that the recommended work RVU is appropriately higher. **The RUC recommends a work RVU of 15.56 for CPT code 59504.**

Postpartum Procedures

Maternal postpartum care includes ongoing assessments tailored to the individual patient. Postpartum care visits are reported as a separately reported E/M service. Immediate (same calendar date) postpartum care is included in vaginal and cesarean delivery care. The postpartum procedures reviewed by the RUC in January 2026 may be separately reported from postpartum E/M visits. The specialty societies stated that there is evidence that perhaps the postpartum hospital stay has shortened for the typical patient, who is instead being seen sooner for an outpatient visit. Like the antepartum care, postpartum care is transitioning toward tailored patient-specific care plans.

**59623 *Uterine tamponade (eg, balloon, catheter, vacuum, packing material)***
The RUC reviewed the survey results from 347 obstetricians, gynecologists, and certified nurse midwives and recommends a work RVU of 2.15 based on a direct work RVU crosswalk to CPT code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 2.15 and 15 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 5 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time, and 30 minutes immediate post-service time. This procedure is not expected to be performed multiple times per day since the uterine tamponade is meant to remain in place for 12 hours and is not removed until there is certainty the bleeding is controlled. This procedure is typically done by the same provider who performed the delivery.

Within the postpartum hemorrhage codes, the surveyed code has more relative intensity than family code 59160. The surveyed code is performed when the bleeding has not yet been controlled by other measures and ultimately requires more invasive procedures for acute hemorrhage management by intrauterine tamponade. These patients have higher procedural intensity due to brisk bleeding and the service is performed only when uterotonic agents or curettage have failed to control the bleeding.

To support the recommended work RVU, the RUC compared the surveyed code to MPC codes 62324 (work RVU = 1.84 and 15 minutes intra-service time) and 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 2.75 and 25 minutes intra-service time). The surveyed code has more total time when compared to both reference codes and is

similar in intensity to the MPC code 52332, which also describes the introduction of a device for acute patient management. Therefore, the recommended work RVU is appropriately bracketed by the reference MPC codes. **The RUC recommends a work RVU of 2.15 for CPT code 59623.**

**59160** ***Curettage, postpartum***
The RUC reviewed the survey results from 339 obstetricians, gynecologists, and family physicians and recommends a work RVU of 2.93 based on a direct work RVU crosswalk to CPT code 69705 *Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral* (work RVU = 2.93 and 20 minutes intra-service time), which maintains relativity within the family for this code. The RUC recommends 20 minutes pre-service evaluation time, 8 minutes pre-service positioning time, 10 minutes scrub/dress/wait time, 21 minutes intra-service time, and 30 minutes immediate post-service time. The global period for this code is changing from a 010-day global to a 000-day global. The specialty societies and RUC agreed a 000-day global period is more appropriate as there is not a post-procedure visit specific to the performance of this procedure.

To support the recommended work RVU, the RUC compared the surveyed code to CPT codes 30140 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)* (work RVU = 2.93 and 20 minutes intra-service time) and 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)* (work RVU = 2.96 and 20 minutes intra-service time). The surveyed code has similar intra-service time and more total time when compared to the reference CPT codes. However, the surveyed code is less intense/complex to perform, suggesting that the work RVU is relative to the reference codes and therefore supported. **The RUC recommends a work RVU of 2.93 for CPT code 59160.**

**Practice Expense**
The RUC acknowledged that a few procedural codes are currently priced in the non-facility setting, but the specialty clarified that this is in error as these services would not be performed in the office. **Therefore, the RUC recommends no direct practice expense inputs for this code family as they are facility-only services.**

**MRA-Head, Neck (Tab 14)**
**Michael Booker, MD (ACR), Robert Bour, MD (ACR), Melissa Chen, MD (ASNR), Andrew Moriarity, MD (ACR), Jacob Ormsby, MD (ASNR)**

In April 2022, the Relativity Assessment Workgroup (RAW) identified services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in 2020 Medicare claims data and/or contained at least one ZZZ global service were removed. The RAW requested action plans for September 2022 to determine if specific codes bundling solutions should occur for 70547 and 70544. In September 2022, the RAW recommended review in 2 years (2021-2022 data) after practice patterns in the inpatient and outpatient setting go back to how they were prior to the pandemic. (Note: 2019 reported together data was 66%). In April 2024, the RAW noted that the rate at which these services are reported together continues to increase (2020=77%, 2021=79% and 2022=81%). The specialty societies recommended, and the RAW agreed that 70547 and 70544 be referred to the CPT Editorial Panel to create a code bundling solution.

At the September 2025 CPT Editorial Panel meeting, CPT codes 70544-70549 were revised to include "image postprocessing," and three codes were created to bundle magnetic resonance angiography (MRA) head and neck with/without contrast. The code family was surveyed for the January 2026 RUC meeting.

**70544** ***Magnetic resonance angiography, head, including image postprocessing; without contrast material(s)***
The RUC reviewed the survey results from 61 diagnostic radiologists and neuroradiologists and determined that the current work RVU of 1.17 appropriately accounts for the physician work involved in this service and that the survey times support the current value. The RUC recommends 4 minutes pre-service time, 13 minutes intra-service time and 4 minutes post-service time.

The RUC compared CPT code 70544 to the top key reference service 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.71, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the head is a comparable service that is typically performed for patients with concern for intracranial vessel narrowing potentially causing cerebral infarction in the acute setting. The specialties noted that magnetic resonance imaging (MRI) is more technically challenging than computed tomography, with the need to understand flow dynamics of vasculature in MRI and MR physics artifacts that contribute to diagnosis, also accounting for the higher intensity. The key reference service is performed with and without contrast, thus requiring more intra-service time, and is therefore appropriately valued higher than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.44, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the magnetic resonance imaging of the brain is a comparable service that is typically performed for patients with concern for worsening headache. The key reference service requires more physician work and time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC referenced MPC code 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU = 1.25, 5 minutes pre-service time, 15 minutes intra-service time, 5 minutes post-service time) which requires more time due to more anatomy being evaluated and is therefore valued higher than the surveyed code. The RUC supports maintaining the current value of CPT code 70544 with times as supported by the survey. **The RUC recommends a work RVU of 1.17 for CPT code 70544.**

**70545** ***Magnetic resonance angiography, head, including image postprocessing; with contrast material(s)***
The RUC reviewed the survey results from 52 diagnostic radiologists and neuroradiologists and determined that the current work RVU of 1.17 appropriately accounts for the physician work involved in this service and that the survey times support the current value. The RUC recommends 5 minutes pre-service time, 15 minutes intra-service time and 4 minutes post-service time.

This family of services is unique in how these sequences are obtained relative to most other magnetic resonance services. For these services, there is advanced physics involved with vascular flow and how the images are obtained and would be in a distinctly different fashion compared to non-contrast and contrasted MRI images of the brain. This results in the code family's rank order being distinct,

where the step-up in value is not analogous to most other magnetic resonance services. That is why the recommended values for 70544 and 70545 are the same.

The RUC compared CPT code 70545 to the top key reference service 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.71, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the head is a comparable service that is performed with and without contrast, thus requiring more intra-service time and greater intensity, justifying a higher value than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.44, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the magnetic resonance imaging of the brain is a comparable service that requires more physician work and time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC references CPT code 73702 *Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.19, 5 minutes pre-service time, 16 minutes intra-service time, 5 minutes post-service time) which requires more time due to having with and without contrast images and is therefore valued higher than the surveyed code. The RUC concluded that these codes support maintaining the value of CPT code 70545 at 1.17 work RVUs. **The RUC recommends a work RVU of 1.17 for CPT code 70545.**

**70546** ***Magnetic resonance angiography, head, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences***
The RUC reviewed the survey results from 52 diagnostic radiologists and neuroradiologists and determined that the current work RVU of 1.44 appropriately accounts for the physician work involved in this service and that the survey times support the current value. The RUC recommends 5 minutes pre-service time, 17 minutes intra-service time and 5 minutes post-service time as supported by the survey.

The RUC compared CPT code 70546 to the top key reference service 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.71, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) noting that the computed tomographic angiography of the head is a comparable service performed with and without contrast and evaluating similar vascular anatomy. The surveyed code would be more likely in the outpatient setting, while the key reference service is typically performed for patients in the acute setting, requiring slightly more intra-service time and intensity, and justifying a higher value than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU = 2.23, 5 minutes pre-service time, 25 minutes intra-service time, 7 minutes post-service time) and noted that the magnetic resonance imaging of the brain is a comparable service performed with and without contrast. The key reference service is typically performed in the outpatient setting for tumors. Both tumors and aneurysms can cause significant morbidity, so the intensity is similar. The difference in physician work and intra-service time is due to the number of sequences and additional anatomy that are evaluated with the reference code compared to the surveyed code.

For additional support, the RUC references CPT code 78072 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization* (work RVU = 1.56, 5 minutes pre-service time, 20 minutes intra-service time, 5 minutes post-service time) which requires more time due to having both the planar images and CT images and is therefore valued higher than the surveyed code. The RUC concluded that these codes support maintaining the value of CPT code 70546 at 1.44 work RVUs. **The RUC recommends a work RVU of 1.44 for CPT code 70546.**

**70547** ***Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s)***
The RUC reviewed the survey results from 56 diagnostic radiologists and neuroradiologists and determined that the current work RVU of 1.17 appropriately accounts for the physician work involved in this service and that the survey times support the current value. The RUC recommends 5 minutes pre-service time, 12 minutes intra-service time and 4 minutes post-service time.

The RUC compared CPT code 70547 to the top key reference service 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.71, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the neck is a comparable service that is typically performed for patients with concern for arterial vessel narrowing/occlusion potentially causing cerebral infarction in the acute setting. The key reference service is performed with and without contrast, therefore requiring more intra-service time, and supporting a higher work value than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.44, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the magnetic resonance imaging of the brain is a comparable service that is typically performed for patients with concern for worsening headache. The key reference service requires more physician work and time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC references CPT code 73702 *Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.19, 5 minutes pre-service time, 16 minutes intra-service time, 5 minutes post-service time) which requires more time due to having with and without contrast images and is therefore valued higher than the surveyed code. The RUC concluded that these codes support maintaining the value of CPT code 70547 at 1.17 work RVUs. **The RUC recommends a work RVU of 1.17 for CPT code 70547.**

**70548** ***Magnetic resonance angiography, neck, including image postprocessing; with contrast material(s)***
The RUC reviewed the survey results from 49 diagnostic radiologists and neuroradiologists and determined that the current work RVU of 1.46 appropriately accounts for the physician work involved in this service and that the survey times support the current value. The RUC recommends 5 minutes pre-service time, 15 minutes intra-service time and 5 minutes post-service time.

Unlike MRA of the head, where there is no step up in work from without contrast to with contrast, the RUC noted that there is a larger step-up in physician work for each code in the MRA of the neck family since the pre-contrast images are acquired using a totally different technique in the axial plane, whereas the post-contrast images are acquired using a different technique in the coronal plane with bolus tracking. The field of view is larger on the post-contrast images, and more structures are

visualized and need to be evaluated, including the aorta and origin of the great vessels. Therefore, the work increment between each MRA of the neck code is greater.

The RUC compared CPT code 70548 to the top key reference service 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.71, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the neck is a comparable service that is typically performed for patients with concern for arterial vessel narrowing/occlusion potentially causing cerebral infarction in the acute setting. The key reference service is performed with and without contrast, therefore requiring more intra-service time, and supporting a higher work value than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.44, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) which is typically performed for patients with concern for worsening headache in the outpatient setting. The RUC noted that the two codes require similar amounts of physician work, yet the surveyed code has greater intensity due to its patient having a more acute/high-risk disease concern and is therefore appropriately valued higher than the reference code.

For additional support, the RUC references CPT code 78072 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization* (work RVU = 1.56, 5 minutes pre-service time, 20 minutes intra-service time, 5 minutes post-service time) which requires more time due to having both the planar images and CT images and is therefore valued higher than the surveyed code. The RUC concluded that these codes support maintaining the value of CPT code 70548 at 1.46 work RVUs. **The RUC recommends a work RVU of 1.46 for CPT code 70548.**

**70549** ***Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences***
The RUC reviewed the survey results from 54 diagnostic radiologists and neuroradiologists and determined that the current work RVU of 1.76 appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes pre-service time, 19 minutes intra-service time and 5 minutes post-service time as supported by the survey.

The RUC compared CPT code 70549 to the top key reference service 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.71, 5 minutes pre-service time, 18 minutes intra-service time, 5 minutes post-service time) noting that the computed tomographic angiography of the neck is a very comparable service performed with and without contrast. These codes have similar times and intensity and therefore support similar work values.

The RUC also compared the surveyed code to the second highest key reference service 70471 *Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing* (work RVU = 2.50, 5 minutes pre-service time, 30 minutes intra-service time, 5 minutes post-service time) which is typically performed for patients with concern for arterial vessel narrowing/occlusion potentially causing cerebral infarction in the acute setting. The key reference service covers both the head and neck instead of just the neck, leading to more time and anatomic coverage overall compared to the surveyed code. The key reference service requires more physician work and time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC references CPT code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.10, 5 minutes pre-service time, 25 minutes intra-service time, 5 minutes post-service time) which requires more time to evaluate more anatomy in the neck due to image acquisition techniques and is therefore valued higher than the surveyed code. The RUC concluded that these codes support maintaining the value of CPT code 70549 at 1.76 work RVUs. **The RUC recommends a work RVU of 1.76 for CPT code 70549.**

**70XX4** ***Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)***

The RUC reviewed the survey results from 55 diagnostic radiologists and neuroradiologists and determined that a direct work RVU crosswalk to CPT code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.77, 5 minutes pre-service time, 25 minutes intra-service time, 5 minutes post-service time) maintains relativity within the code family and appropriately accounts for the physician work required for this service. The RUC recommends 5 minutes pre-service time, 20 minutes intra-service time and 4 minutes post-service time as supported by the survey. This new CPT code bundles the physician work previously reported separately using CPT code 70544 and 70547. The RUC noted that the crosswalk code has more intra-service time due to greater anatomy coverage; however, the surveyed code has a more intense patient population, including patients with an acute stroke and potential need for thrombectomy. Furthermore, the crosswalk value better aligns with the overall intensity in relation to the other MRA stand-alone codes. Magnetic resonance imaging is more technically challenging than computed tomography, with the need to understand flow dynamics of vasculature in MRI and MR physics artifacts that contribute to diagnosis, also accounting for the higher intensity.

The RUC compared CPT code 70XX4 to the top key reference service 70471 *Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing* (work RVU = 2.50, 5 minutes pre-service time, 30 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the head and neck is a comparable service that is performed with and without contrast, therefore requiring more intra-service time, and supporting a higher work value than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service, MPC code 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU = 1.96, 5 minutes pre-service time, 30 minutes intra-service time, 5 minutes post-service time), which is typically performed for renal pathology in the outpatient setting. The RUC noted that the key reference service requires more intra-service time, due to being performed with and without contrast over a larger anatomic area and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC references CPT code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.10, 5 minutes pre-service time, 25 minutes intra-service time, 5 minutes post-service time) which requires more time due to evaluating more anatomy in the neck due to image acquisition techniques and is with and without contrast and is therefore valued higher than the surveyed code. The RUC concluded that these codes support crosswalk to CPT code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.77, 5 minutes pre-service time, 25

minutes intra-service time, 5 minutes post-service time). **The RUC recommends a work RVU of 1.77 for CPT code 70XX4.**

**70XX5** ***Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)***
The RUC reviewed the survey results from 50 diagnostic radiologists and neuroradiologists and determined that a direct work RVU crosswalk to CPT code 73720 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.10, 5 minutes pre-service time, 24 minutes intra-service time, 5 minutes post-service time) maintains relativity within the code family and appropriately accounts for the physician work required for this service. The RUC recommends 5 minutes pre-service time, 22 minutes intra-service time and 5 minutes post-service time as supported by the survey. This new CPT code bundles the physician work previously reported separately using CPT code 70545 and 70548.

The RUC noted that the crosswalk code has more intra-service time due to more sequences to review non-contrasted and contrasted images; however, the surveyed code has a more complex patient population with patients who previously underwent prior procedure presenting with acute neurologic symptoms. Furthermore, the crosswalk value better aligns with the overall intensity in relation to the other MRA stand-alone codes.

The RUC compared CPT code 70XX5 to the top key reference service 70471 *Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing* (work RVU = 2.50, 5 minutes pre-service time, 30 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the head and neck is a comparable service that is performed with and without contrast, therefore requiring more intra-service time, and supporting a higher work value than the surveyed code.

The RUC also compared the surveyed code to the second highest key reference service 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU = 2.23, 5 minutes pre-service time, 25 minutes intra-service time, 7 minutes post-service time) noting that the key reference service is performed with and without contrast and requires more intra-service time, therefore it is appropriately valued higher than the surveyed code.

For additional support, the RUC references CPT code 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.15, 5 minutes pre-service time, 30 minutes intra-service time, 5 minutes post-service time) which requires more time due to more anatomy in the abdomen being evaluated relative to the vessels of the head and neck and is therefore valued higher than the surveyed code. The RUC concluded that these codes support crosswalk to CPT code 73720 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.10, 5 minutes pre-service time, 24 minutes intra-service time, 5 minutes post-service time). **The RUC recommends a work RVU of 2.10 for CPT code 70XX5.**

**70XX6** ***Magnetic resonance angiography, head and neck, without contrast material(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing***

The RUC reviewed the survey results from 52 diagnostic radiologists and neuroradiologists and determined that a direct work RVU crosswalk to MPC code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU = 2.23, 5 minutes pre-service time, 25 minutes intra-service time, 5 minutes post-service time) maintains relativity within the code family and appropriately accounts for the physician work required for this service. The RUC recommends 5 minutes pre-service time, 25 minutes intra-service time and 5 minutes post-service time as supported by the survey. This new CPT code bundles the physician work previously reported separately using CPT code 70546 and 70549.

The RUC noted that the crosswalk code has identical times as the surveyed code, given that these are both magnetic resonance exams performed with and without contrast with focused anatomy. The codes also share identical intensity as both services have potential for severe morbidity issues (related to back pain with potential for tumor as the underlying cause, compared to a patient with potential stroke). The RUC further noted that the crosswalk value better aligns with the overall intensity in relation to the other MRA stand-alone codes.

The RUC compared CPT code 70XX6 to the top key reference service 70471 *Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing* (work RVU = 2.50, 5 minutes pre-service time, 30 minutes intra-service time, 5 minutes post-service time) and noted that the computed tomographic angiography of the head and neck is a comparable service performed with and without contrast, yet requiring more intra-service time than the surveyed code and is therefore appropriately valued higher. The RUC further noted that, while the key reference service has more intra-service time, knowing the artifacts related to magnetic resonance, including phase-encoding artifacts and frequency encoded artifacts, along with how time of flight is processed, makes the surveyed code more technically challenging.

The RUC also compared the surveyed code to the second highest key reference service 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU = 2.93, 12.5 minutes pre-service time, 60 minutes intra-service time, 10 minutes post-service time) which is typically performed in the outpatient setting and looking for pathologies related to chronic heart disease. The RUC noted that the surveyed code is much more intense due to the acute patient population requiring potential urgent intervention if there is aneurysmal rupture or infarct. The key reference service is performed with and without contrast, yet requires much more intra-service time due to more sequences and having to evaluate cine clips of the heart and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC references CPT code 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU = 2.34, 5 minutes pre-service time, 40 minutes intra-service time, 5 minutes post-service time) which requires more time due to the entirety of the colon being larger than the vessels with multiple passes needed when evaluating the 3D post processed images for cancer and is therefore valued higher than the surveyed code. The RUC concluded that CPT code 70XX6 should be valued based on a direct work RVU crosswalk to MPC code 72158 with times as supported by the survey. **The RUC recommends a work RVU of 2.23 for CPT code 70XX6.**

**Practice Expense**
The Practice Expense (PE) Subcommittee reviewed the direct inputs and made a single modification to add a pair of SB022 *gloves, non-sterile* to all studies that included contrast, as they are needed to remove the IV at the end of these studies. The Subcommittee requested further justification for clinical staff times above the standard for CA013, CA016, and CA030 and additional explanation for CA021. The specialties have provided this information in their PE SOR. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

**Biofeedback Training (Tab 15)**
**Seth Cohen, MD (AUA), Jon Hathaway, MD (ACOG), Dave Holtz, MD (ACOG), Jonathan Kiechle, MD (AUA), Angela Pennisi, PT, DPT (APTA), Richard Rausch, DPT (APTA)**

In January 2019, CPT code 90912 and ZZZ add-on code 90913 were surveyed for the January 2019 RUC meeting, both of which were later identified as family services related to newly edited/created CPT codes 90901 and 909X3. In April 2023, the Relativity Assessment Workgroup (RAW) identified CPT code 90901 via the high-volume growth screen with 2021 Medicare utilization of 10,000 or more than increased by at least 100% from 2016 through 2021. In September 2023, the RAW reviewed the action plan for CPT code 90901 and agreed with the specialty societies that 90901, along with the other services in this code family (90912 and 90913), should be surveyed for the April 2024 RUC meeting. However, when the specialty societies were preparing to survey the services, they determined they could not proceed and instead requested to revise the code family through the CPT process before surveying. While there is no change in work for these two codes since they were last surveyed, both CPT codes 90912 and 90913 were surveyed for the January 2026 RUC meeting, separately from CPT codes 90901 and 909X3, which were surveyed for RUC HCPAC review.

**90912** ***Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient***
The RUC reviewed survey results from 68 physicians and recommends the survey median work RVU of 0.90, which is consistent with the current value and appropriately accounts for the physician work typically required to perform this service. The RUC recommends 7 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 3 minutes of pre-service scrub/dress/wait time, 15 minutes of intra-service time, and 5 minutes of immediate post-service time.

The typical patient for this service will have an internal sensor placed in either the vagina or the rectum to measure muscular activity through the procedure. An external sensor is also typically placed to measure the activity of the external urethral sphincter throughout this procedure. The internal sensor will often require readjustment during the procedure, as patient movement can lead to malposition. The efficacy of the biofeedback treatment relies on appropriate sensor readings so that the physician can determine if the patient is activating the appropriate muscles throughout the procedure. CPT code 90912 is a time-based service that requires one-on-one physician or qualified health professional (QHP) contact with the patient through the entire time of service.

To support the recommended work RVU of 0.90, the RUC compared the surveyed code to the top key reference service 97112 *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception*

*for sitting and/or standing activities* (work RVU = 0.50, 15 minutes intra-service time). The RUC recognized that while both codes typically involve the same amount of intra-service time, the surveyed code requires nearly twice as much total time. It is appropriate that the surveyed code has a higher work RVU given it requires more physician work and time and has a higher intensity/complexity to perform overall.

For additional support, the RUC compared the surveyed code to CPT code 57160 *Fitting and insertion of pessary or other intravaginal support device* (work RVU = 0.87, 15 minutes intra-service time). The RUC recognized that this reference code requires identical intra-service time and almost the same amount of total time as the surveyed code. Overall, the RUC recommendation of the survey median work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services in the Medicare Physician Payment Schedule (MFS). **The RUC recommends a work RVU of 0.90 for CPT code 90912.**

**90913** ***Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 67 physicians and recommends the survey 25th percentile work RVU of 0.50, which is consistent with the current value and appropriately accounts for the physician work typically required to perform this service. The RUC recommends 15 minutes of intra-service time. Like CPT code 90912, this add-on code is a time-based service that requires one-on-one physician or QHP contact with the patient through the entire time of service. The CY 2024 Medicare claims data demonstrate that it is typical for only one unit of the add-on code to be reported with the base code, and base code 90912 is reported with add-on code 90913 66 percent of the time.

To support the recommended work RVU of 0.50, the RUC compared the surveyed code to the top key reference service 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48, 15 minutes intra-service time) and second key reference service 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.78, 15 minutes intra-service time). The RUC recognized that both key reference services require identical intra-service time and together bracket the survey 25th percentile work RVU of 0.50.

For additional support, the RUC compared the surveyed code to MPC codes 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* (work RVU = 0.37, 15 minutes intra-service time) and 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)* (work RVU = 0.53, 15 minutes intra-service time). Both MPC codes require identical intra-service time, and together these services bracket the survey 25th percentile work RVU of 0.50. Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services in the MFS. **The RUC recommends a work RVU of 0.50 for CPT code 90913.**

**Practice Expense**
The Practice Expense (PE) Subcommittee discussed the compelling evidence argument that there was an error in prior valuation that omitted two sanitizing wipes, SM021 *sanitizing cloth-wipe (patient)* and SM022 *sanitizing cloth-wipe (surface, instruments, equipment),* for CPT codes 90901 and 90912. Only code 90912 requires compelling evidence, and it was approved. The specialty societies explained that a patient cleansing wipe is typical when a patient has gel to wipe off, and it is typical to sanitize equipment after use.

The PE Subcommittee reviewed the direct practice expense inputs and made one modification to CPT code 90912 to adjust the quantity of supply item SK068 *razor* from 0.2 to 1, as it is not typical for the razor to be saved for subsequent patient visits. While supply item SD113 *sensor, EMG, vaginal-rectal* quantity remains 0.2 because there are typically 5 treatments and one sensor/probe is used per patient, not per session (ie, the sensor is labeled for a single patient's use and disposed after final treatment). **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

**Video Head Impulse – Vestibular Function (Tab 16)**
**Deborah Carlson, PhD (ASHA), Patricia Gaffney, AuD (AAA), Justin Hoskin, MD (AAN), Erin L. Miller, AuD (AAA), Paul Pessis, AuD (AAA), Marianna Spanaki, MD (AAN)**

In September 2025, the CPT Editorial Panel approved the addition of two codes to report video head impulse testing (vHIT) and a corresponding parenthetical note. The two new codes describe vHIT for assessment of semicircular canal function: 92X10 describes testing of lateral (horizontal) semicircular canal function only, and 92X11 describes testing of all six semicircular canals (lateral plus the vertical planes). Note, the codes are separate stand-alone codes and neither of them are add-on services. vHIT addresses a specific patient population with impaired vestibular function and is most commonly performed in vestibular centers by subspecialized audiologists and neurologists. For vHIT, audiology serves as the primary performer of the service, while neurology may sometimes perform and indicated a level of interest in surveying the new codes.

The RUC discussed the differences between vHIT and rotary chair services reviewed in September 2025. vHIT tests high-frequency, short-latency vestibulo-ocular reflex (VOR) function of each individual semicircular canal during rapid, unpredictable head movements, while rotary chair testing evaluates overall vestibular system function across low-to-mid frequencies using controlled, sinusoidal or step rotations that reflect bilateral vestibular performance.

**92X10** ***Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral semicircular canal function***
The RUC reviewed the survey results from 111 audiologists and neurologists and determined that a direct work RVU crosswalk to MPC code 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU = 0.53, 2 minutes pre-service time, 10 minutes intra-service time, 10 minutes post-service time), which has identical intra-service time and falls between the survey 25$^{th}$ percentile and the median, appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service time, and 6 minutes post-service time as supported by the survey. Multiple specialties were involved in the survey process, and the RUC was deliberate in recommending the combined survey times for its valuation as is typical.

To justify the crosswalk value of 0.53 work RVUs, the RUC compared CPT code 92X10 to the top key reference service 92517 *Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)* (work RVU = 0.78, 7 minutes pre-service time, 20 minutes intra-service time, 5 minutes post-service time) and noted that VEMP testing is a comparable service, as both codes evaluate specific components of the vestibular system using specialized recording equipment and require clinical interpretation of physiologic signals. The RUC noted that the key reference service requires twice as much intra-service time, and therefore, it is appropriately valued higher than the surveyed code. The RUC also noted that the intensity of the surveyed code aligns with the other vestibular codes, thus supporting the crosswalk value. Both vHIT and CPT 76519 are device-assisted, operator-driven diagnostic services requiring moderate-to-high technical skill, physician/QHP cognitive effort, and clinical responsibility through structured protocols, artifact mitigation, and interpretation beyond simple screening.

For additional support, the RUC compared the surveyed code to CPT code 92542 *Positional nystagmus test, minimum of 4 positions, with recording)* (work RVU = 0.47, 3 minutes pre-service time, 10 minutes intra-service time, 3 minutes post-service time) and noted the identical intra-service times and similar amount of work involved, as both services use similar eye-movement recording equipment; however, 92X10 has significantly more post-time required. **The RUC recommends a work RVU of 0.53 for CPT code 92X10.**

**92X11** ***Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral and vertical semicircular canal function***

The RUC reviewed the survey results from 108 audiologists and neurologists and determined that a direct work RVU crosswalk to CPT code 95938 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs* (work RVU = 0.84, 10 minutes pre-service time, 20 minutes intra-service time, 10 minutes post-service time), which falls between the survey 25th percentile and the median, appropriately accounts for the physician work involved in this service. The RUC recommends 6 minutes pre-service time, 18 minutes intra-service time, and 8 minutes post-service time as supported by the survey. Multiple specialties were involved in the survey process, and the RUC was deliberate in recommending the combined survey times for its valuation as is typical.

Both 92X11 and 95938 are multicomponent neurodiagnostic physiologic studies that stimulate peripheral sensory systems and record centrally mediated responses to assess neural pathway integrity. They require structured protocols, real-time monitoring, multi-parameter data acquisition, and physician/QHP interpretation of complex waveforms—elevating cognitive and technical complexity beyond simpler screening tests.

To further justify the crosswalk value of 0.84 work RVUs, the RUC compared the surveyed code to the top key reference service 92519 *Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)* (work RVU = 1.17, 10 minutes pre-service time, 35 minutes intra-service time, 5 minutes post-service time) and noted that VEMP testing is a comparable service that requires nearly twice as much intra-service time and is therefore appropriately valued higher than the surveyed code.

For additional support, the RUC referenced several codes that are supportive of the crosswalk recommendation including MPC codes 92517 *Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)* (work RVU = 0.78, 7 minutes pre-service time, 20 minutes intra-service time, 5 minutes post-service time) and 95971 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable*

*parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RVU = 0.78, 8 minutes pre-service time, 20 minutes intra-service time, 5 minutes post-service time) which share the same work value and intra-service time as the surveyed code.

Also, CPT codes 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (work RVU = 0.88, 5 minutes pre-service time, 16 minutes intra-service time, 6 minutes post-service time); 93985 *Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study* (work RVU = 0.78, 5 minutes pre-service time, 17 minutes intra-service time, 5 minutes post-service time); and 95800 *Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time* (work RVU = 0.83, 6 minutes pre-service time, 15 minutes intra-service time, 10 minutes post-service time) which are all valued similarly and require similar intra-service time as the surveyed code. **The RUC recommends a work RVU of 0.84 for CPT code 92X11.**

**Practice Expense**
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee acknowledged that there are no clinical activities associated with this code family, as the physician/audiologist time to perform the vHIT is accounted for in the work, and no clinical staff are involved in the procedure. The PE Subcommittee approved the inputs, including one new supply item, *Face cushion*, and 3 new equipment items: *Monocular Video Frenzel base unit with vestibular software*, *Lateral VHIT module*, and *Larp/Ralp module*. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

**New Technology**
CPT codes 92X10 and 92X11 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Fine Needle Aspiration (Tab 17)**
**Curtis Anderson, MD (OEIS), Michael Booker, MD (ACR), Chase Hendrickson, MD (ES), Minhajuddin Khaja, MD (SIR), Michael Morkos, MD (AACE), Emily Volk, MD (CAP)**

In the Proposed Rule for 2026, an interested party requested that CMS reconsider CPT codes 10021 *Fine needle aspiration biopsy, without imaging guidance; first lesion*, 10004 *Fine needle aspiration biopsy, without imaging guidance; each additional lesion,* 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* and 10006 *Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion* for nomination as potentially misvalued, citing significant undervaluation since 2019. The nominator submitted a request to CMS for the reevaluation of these codes, stating that the payment changes have created a concerning cascade of negative consequences impacting the care of patients with thyroid nodules and cancer. Specifically, the nominator questioned the fundamental basis of CMS' 2019 work RVU reductions for fine needle aspiration (FNA) procedures.

CMS noted that they appreciated the comprehensive information provided by the nominator, including their reference to recent research and detailed trend analysis. However, these codes have undergone multiple recent reviews. CMS' review of these codes and rationale for finalizing the current values are extensively discussed in the MFS Final Rule for 2019 (83 FR 59517) and MFS Final Rule for 2021 (85 FR 84599). Furthermore, this code family was previously nominated two

separate years as potentially misvalued and discussed in the MFS Final Rule for 2020 (84 FR 62625) and MFS Final Rule for 2025 (89 FR 97743). CMS maintained its position and did not propose this code family as potentially misvalued. CMS acknowledges the shift in the site of service for FNA procedures between 2018 and 2023. CMS indicated they do not currently consider these changes substantial enough to warrant immediate revaluation and will continue to monitor the site-of-service trends closely. Should these patterns persist or accelerate, a new survey in the future may be necessary to accurately reflect these changes in practice patterns. CMS indicated that they welcome public comments and recommendations, including those from the RUC, regarding whether these codes should be re-reviewed considering the information submitted by the nominator.

The RUC received notification of interest from the American Association of Clinical Endocrinology to re-review CPT codes 10005 and 10006. The RUC placed the fine needle aspiration codes (10005 and 10006) on the Level of Interest (LOI) form to review these services at the January 2026 meeting and submit recommendations for the 2027 MFS.

**10005** ***Fine needle aspiration biopsy, including ultrasound guidance; first lesion***
The RUC reviewed the survey results from 268 physicians and determined that the survey 25th percentile work RVU of 1.35 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service evaluation time, 20 minutes intra-service time and 10 minutes immediate post-operative time.

The specialty societies noted that the typical number of samples obtained has changed slightly over the years. Six samples are typically obtained now per lesion, four for the thyroid nodule for cytology and two for molecular sequencing.

The RUC compared the surveyed code to the top two key reference services 77012 *Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation* (work RVU = 1.46 and 35 minutes intra-service time) and CPT 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 and 30 minutes intra-service time) and determined that the surveyed code requires slightly less physician time and work to perform than both key reference services. Therefore, the surveyed code is appropriately valued lower.

For additional support, the RUC referenced MPC codes 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 and 20 minutes intra-service time) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (work RVU = 1.60 and 25 minutes intra-service time) and noted these services appropriately bracket the surveyed service and demonstrate the appropriate relativity across the MFS. **The RUC recommends a work RVU of 1.35 for CPT code 10005.**

**10006** ***Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 259 physicians and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this add-on service. The RUC recommends 17 minutes of intra-service time.

The specialty societies noted that the typical number of samples obtained has changed slightly over the years. Six samples are typically obtained now per lesion, four for the nodule for cytology and two for molecular sequencing. The intra-service time increased by two minutes, from 15 to 17, which accounts for the additional samples being obtained. The RUC determined that a slight increase in work RVU was appropriate due to the slight increase in time and the number of biopsies obtained.

The RUC compared the surveyed code to the top key reference service 19084 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)* (work RVU = 1.51 and 20 minutes intra-service time) and determined that the surveyed code requires slightly less physician time and work to perform. Therefore, the surveyed code is appropriately valued lower.

The RUC compared the surveyed code to the second top key reference service 10036 *Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU = 0.83 and 14 minutes intra-service time) and determined that the surveyed code requires slightly more physician time and work to perform. Therefore, the surveyed code is appropriately valued higher.

For additional support, the RUC referenced MPC code 52442 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)* (work RVU = 0.98 and 15 minutes intra-service time) and noted this service requires similar time and physician work, thus demonstrates the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.00 for CPT code 10006.**

**Practice Expense**
The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that the procedure has changed necessitating changes in clinical staff, supplies, and equipment. The PE Subcommittee noted that Diagnostic Radiology (41%) is the primary specialty providing services in the facility setting and Endocrinology (31.5%) is the primary provider in the office setting. The specialty societies submitted an updated invoice for equipment item EQ250 *ultrasound unit, portable* which has increased over 100%. The PE Subcommittee verified that the portable ultrasound unit interacts with Picture Archiving and Communication Systems (PACS), and images can go back and forth. Therefore, the Subcommittee modified the PE inputs to include the *L051B RN/Diagnostic Medical Sonographer* blend as clinical staff, the film-to-digital standards, and the technologists' PACS workstation equipment usage calculations. The PE Subcommittee confirmed that in the office setting the clinical staff is either a trained RN or sonographer who can hold and adjust the probe and upload to the PACS. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

**Percutaneous Transcatheter Closure (Tab 18)**
**Mark Schoenfeld, MD, (HRS), David Slotwiner, MD (HRS), Afnan Tariq, MD (SCAI), Edward Tuohy, MD (ACC), Richard Wright, MD (ACC)**

In April 2025, the Relativity Assessment Workgroup identified CPT code 33340 with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. The specialty societies indicated and the RUC agreed that CPT code 33340 be surveyed for the January 2026 RUC meeting.

**Compelling Evidence**
The specialty society indicated incorrect assumptions were made in the previous valuation of CPT code 33340. The specialty societies stated that the April 2024 survey was flawed due to the lack of availability of appropriate codes for the reference service list (RSL) and crosswalk codes. Catheter services for percutaneous coronary interventions and lower extremity revascularization were also under review at that time. While the current valuation by crosswalk to an abdominal hernia repair code aligned with the intraservice minutes, it failed to incorporate any increased complexity for performing a complex, transseptal, intracardiac catheter procedure. The specialty societies believe the recent valuation creates anomalous relationships between 33340 and other catheter-based therapy codes. For example, at the current work RVU of 9.99, CPT code 33340 is lower than the less intense service of 92937 *Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed, single major coronary artery and/or its branches* (work RVU = 11.02 and 65 minutes intra-service time).

The RUC indicated that the April 2024 valuation was based on a crosswalk to 49614 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated* (work RVU = 9.99 (10.25 prior to efficiency adjustment and 75 minutes intra-service time), which the RUC believed maintained relativity within the Medicare Physician Payment Schedule (MFS). Additionally, the RUC determined that not having the percutaneous coronary intervention and lower extremity revascularization codes on the RSL that were also under review at the time of the last survey did not affect the survey responses. The key reference service chosen in both the April 2024 survey and the January 2026 survey was 93656 *Comprehensive electrophysiologic evaluation with transseptal catheterizations, insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography with imaging supervision and interpretation, right ventricular pacing/recording, and His bundle recording, when performed* (work RVU = 16.58 and 180 minutes intra-service time). Additionally, the second top key reference service chosen in both surveys were also percutaneous transcatheter closure codes, 93581 and 93591, which were both on the RSL in the April 2024 survey. CPT code 93581 was the second top key reference service selected in the April 2024 survey and CPT code 93591 was the second top key reference service selected in the January 2026 survey. Adding the lower extremity revascularization codes and percutaneous coronary intervention codes did not alter the survey results. The RUC determined that the RSLs were appropriate and the previous survey was not flawed due to a lack of comparable services. **The RUC did not believe there was compelling evidence that incorrect assumptions were made in the previous valuation (April 2024) of CPT code 33340.**

**33340** ***Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation***
The RUC reviewed the survey results from 121 physicians and determined that the current work RVU of 9.99 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes pre-evaluation time, 3 minutes positioning time, 15 minutes scrub/dress/wait time, 62 minutes intra-service time, and 29 minutes immediate post-service time as supported by the survey.

This service is typically performed on a patient under general anesthesia. An additional 5 minutes of pre-service evaluation time is required for the operator to review cardiac CT images to fine-tune pre-procedure planning for placement of the occlusion device. This service is the transcatheter closure of the left atrial appendage, performed via a catheter. This is distinct from the surgical closure, which can be performed by surgeons using thoracoscopy. Although a 000-day global, this service is a major surgical procedure, exclusively performed in a hospital, and the patient is typically discharged one day later.

The RUC compared the surveyed code to the top two key reference services 93656 *Comprehensive electrophysiologic evaluation with transseptal catheterizations, insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography with imaging supervision and interpretation, right ventricular pacing/recording, and His bundle recording, when performed* (work RVU = 16.58 and 180 minutes intra-service time) and CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.52 and 120 minutes intra-service time) and determined that the key reference codes require more physician work and time, thus are valued higher.

For additional support, the RUC referenced codes 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments* (work RVU = 9.75 and 60 minutes intra-service time) and 92937 *Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed, single major coronary artery and/or its branches* (work RVU = 11.02 and 65 minutes intra-service time) and noted these services require similar physician time and work and demonstrate the appropriate relativity across the MFS. **The RUC recommends a work RVU of 9.99 for CPT code 33340.**

**Practice Expense**
The Practice Expense Subcommittee noted that the specialties recommended the standard 000-day pre-service time package for Extensive Use of Clinical Staff in the facility for CPT code 33340 and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies**.

**Treatment of Incompetent Veins (Tab 19)**
**Curtis Anderson, MD (OEIS), Michael Booker, MD (ACR), , Michael Di Iorio, MD (AVLS), Mark Iafrati, MD (SVS), Minhajuddin Khaja, MD (SIR), Jonathan Thompson, MD (SVS)**

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 36465 with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. The RAW reviewed the action plan and the RUC recommended CPT code 36465 along with the

family of services be surveyed for the January 2026 RUC meeting. This family of services includes all sclerosant treatment of incompetent veins.

**36470** ***Injection of sclerosant; single incompetent vein (other than telangiectasia)***
The RUC reviewed the survey results from 86 physicians and determined the current work RVU of 0.73 accounts for the work required to perform this service. The specialty society expert panel reviewed the survey data and concluded that the services have not evolved in a way that would justify the increased work values at the 25th percentile, therefore, the specialty societies and RUC agreed that maintaining the current value was appropriate. The RUC recommends 9 minutes pre-evaluation time, 1 minute scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time as supported by the survey.

The RUC indicated that 2 minutes were added to the evaluation time, 1 minute to allow preparation of the sclerosant and an additional 1 minute to mark the site for injection. The specialty societies clarified that this service is typically not performed under local anesthesia. Therefore, the 1 minute of scrub, dress and wait time is not for administering local/topical anesthesia as indicated in pre-time package 5 *Procedure with minimal anesthesia care* but instead is for scrubbing the site to prepare for the injection.

To support maintaining the current value, the RUC compared the surveyed code to the top two key reference services 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.29 and 30 minutes intra-service time) and CPT code 36002 *Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm* (work RVU = 1.91 and 30 minutes intra-service time) and determined that the surveyed code requires much less physician time and is less intense and complex to perform than both key reference services. Therefore, the surveyed code is appropriately valued lower.

For additional support, the RUC referenced codes 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)* (work RVU = 0.74 and 15 minutes intra-service time) and 97597 *Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less* (work RVU = 0.75 and 15 minutes intra-service time) and noted these services require similar physician time and work and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 0.73 for CPT code 36470.**

**36471** ***Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg***
The RUC reviewed the survey results from 88 physicians and determined a work RVU of 1.18 appropriately accounts for the work required to perform this service based on a direct crosswalk to CPT code 36597 *Repositioning of previously placed central venous catheter under fluoroscopic guidance* (work RVU = 1.18 and 20 minutes intra-service time). The surveyed intra-service time decreased by 10 minutes compared to the existing time, while the intensity of the service has remained unchanged. Given that there have been no significant changes in technique, patient population, or other relevant factors, the specialty societies recommended, and the RUC agreed to crosswalk to CPT code 36597. This more accurately reflects the reduced intra-service time without changing the intensity and aligns with current practice to perform 36471.

The RUC recommends 12 minutes pre-evaluation time, 1 minute scrub/dress/wait time, 20 minutes intra-service time and 10 minutes immediate post-service time. The RUC indicated that 5 minutes were added to the evaluation time, an additional 2 minutes for preparation of the sclerosant, and an additional 3 minutes to mark the multiple sites for injection. The specialty societies noted that the surveyed code is for multiple veins, which require multiple syringes to be used, and therefore, one additional minute compared to family code 36470 to prepare the extra syringes is appropriate. The specialty societies clarified that this service is typically not performed under local anesthesia. Therefore, the 1 minute of scrub, dress and wait time is not for administering local/topical anesthesia as indicated in pre-time package 5 *Procedure with minimal anesthesia care* but instead is for scrubbing the site to prepare for the injection.

To support the crosswalk value, the RUC compared the surveyed code to the top two key reference service 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.29 and 30 minutes intra-service time) and CPT code 36002 *Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm* (work RVU = 1.91 and 30 minutes intra-service time) and determined that the surveyed code requires much less physician time than both key reference services. Therefore, the surveyed code is appropriately valued lower.

The RUC noted that CPT code 30905 *Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial* (work RVU = 1.92 and 20 minutes intra-service time) and 46601 *Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed* (work RVU = 1.56 and 20 minutes intra-service time) are similar services that both require 20 minutes of intra-service time. The RUC noted that the recommended crosswalk value of 1.18 is at the lower end of similar services but is acceptable.

For additional support, the RUC referenced code 45340 *Sigmoidoscopy, flexible; with transendoscopic balloon dilation* (work RVU = 1.22 and 20 minutes intra-service time) and noted that this service require similar physician time and work and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.18 for CPT code 36471.**

**36465 *Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)***
The RUC reviewed the survey results from 84 physicians and determined that the current work RVU of 2.29 accounts for the work required to perform this service. The specialty society expert panel reviewed the survey data and concluded that the services have not evolved in a way that would justify the increased work values at the 25$^{th}$ percentile, therefore, the specialty societies and RUC agreed that maintaining the current value was appropriate. The RUC recommends 17 minutes pre-evaluation time, 4 minutes pre-positioning time, 7 minutes scrub/dress/wait time, 25 minutes intra-service time and 10 minutes immediate post-service time as supported by the survey.

The RUC indicated that 3 minutes were added to positioning time to adequately adjust the patient's extremity for access to the saphenous vein and 2 minutes added to the scrub/dress/wait time as a sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, which requires scrubbing and sterile gown and masks and gloves for the physician and clinical staff, as indicated by the survey. The patient is required to lie supine. The leg is externally rotated to allow access to the vein and to allow for proper examination of the entire saphenous vein along its length to allow for a necessary ultrasound for guidance. The leg needs to be

raised above the head, and then during access needs to be brought below the heart to ensure that the vein is ready for access. Then pads are appropriately placed to begin the procedure.

CPT code 36465 is the larger truncal ablation of the larger superficial veins in the leg, different than and requiring more physician work and time to perform than CPT codes 36470 and 36471, which are injections of sclerosant for abnormal superficial varicosities. The utilization of the surveyed code and code 36466 has increased because they are vein adjunct services that do not require tumescent anesthesia, which would require multiple injections throughout the leg to in order to numb it and often would require additional anesthesia (15-30 needle pokes) throughout the procedure. The surveyed code requires one limited access to inject the medicine (foam), whereas tumescent based services require access, a laser or radiofrequency, and use of saline and other fluids to numb the entire vein. Therefore, due to increased patient comfort and efficacy, there has been a shift to perform these non-tumescent based codes for vein care.

To support maintaining the current value, the RUC compared the surveyed code to the top key reference service 36482 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated* (work RVU = 3.41 and 35 minutes intra-service time) and determined that the surveyed code requires less physician time and is less intense and complex to perform than CPT code 36482. Therefore, the surveyed code is appropriately valued lower.

The RUC compared the surveyed code to the second key reference service 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.29 and 30 minutes intra-service time) and these service require the same physician work and similar total time to perform. Thus, they are appropriately valued the same.

For additional support, the RUC referenced MPC code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 2.75 and 25 minutes intra-service time) and code 52204 *Cystourethroscopy, with biopsy(s)* (work RVU = 2.53 and 25 minutes intra-service time) and noted these services require similar physician time and work and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 2.29 for CPT code 36465.**

**36466 *Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg***
The RUC reviewed the survey results from 83 physicians and determined the current work RVU of 2.93 appropriately accounts for the work required to perform this service. The specialty society expert panel reviewed the survey data and concluded that the services have not evolved in a way that would justify the increased work values at the 25$^{th}$ percentile, therefore, the specialty societies and RUC agreed that maintaining the current value was appropriate. The RUC recommends 17 minutes pre-evaluation time, 4 minutes pre-positioning time, 7 minutes scrub/dress/wait time, 30 minutes intra-service time and 10 minutes immediate post-service time as supported by the survey.

The RUC indicated that 3 minutes were added to positioning time to adequately adjust the patient's extremity for access to the saphenous veins and 2 minutes added to the scrub/dress/wait time as a sterile operating room technique is maintained for this procedure when performed in an office

procedure/surgery suite, which requires scrubbing and sterile gown, and masks and gloves for the physician and clinical staff.

The specialty societies indicated that the patient population is different now and requires greater complexity in dealing with a different vein than previously. The specialty societies identified an inconsistency in the vignette for the surveyed code. It previously read, "A female patient has painful, unilateral leg swelling that increases during the course of the day while at her job, which requires her to stand for a significant portion of the day. She was diagnosed with **great saphenous vein** and **small saphenous vein** insufficiency with resultant superficial varicosities. She chooses to undergo foam chemical ablation of the **great saphenous** and **anterior accessory saphenous veins** under local anesthesia."

This vignette may have been misleading. When the prior surveyees read the vignette, it is not clear whether they were valuing the great saphenous and small saphenous (where the venous insufficiency exists) or whether they were valuing the great and anterior accessory saphenous veins (as is described). It is unusual to treat a vein that does not have documented reflux. The specialty societies believe the language led to confusion and flawed survey results previously.

For the current survey, the specialty societies revised the vignette to clearly define the veins that are being treated. "A 65-year-old female has painful, unilateral leg swelling that increases during the course of the day. She was diagnosed with **great saphenous** vein and **small saphenous** vein insufficiency with resultant superficial varicosities. She undergoes foam chemical ablation of the **great saphenous** and **small saphenous** veins under local anesthesia."

The great saphenous vein runs along the posterior medial part of the leg, while the anterior accessory saphenous vein runs along the anterior medial part of the thigh, and the small saphenous vein is located in the posterior calf. These patients are all in the supine position and accessing the small saphenous vein is difficult in that position. The ultrasound and needle are upside down and backwards. It is technically and mentally more challenging because the physician essentially must flip the ultrasound and needle position during the access portion. When the physician injects the medication to ablate the vein, they are looking with that ultrasound probe upside down. The small saphenous vein along the calf is 20-25 centimeters, whereas the anterior accessory saphenous vein, which was treated and surveyed in the prior vignette, is 35-40 centimeters. Therefore, the time needed to inject and compress along the length of that vein is shorter, which explains the slight decrease in time and justifies the slightly higher intensity.

To support maintaining the current value, the RUC compared the surveyed code to the top key reference service 36482 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated* (work RVU = 3.41 and 35 minutes intra-service time) and determined the surveyed code requires less time. Therefore, the surveyed code is appropriately valued lower.

The RUC compared the surveyed code to the second key reference service 49185 *Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed* (work RVU = 2.29 and 30 minutes intra-service time) and determined that these services require similar time to perform, but the surveyed code is much more intense and complex to perform. Of the respondents who chose CPT code 49185 as the key reference service, 64% indicated that the surveyed code overall was more intense and complex to perform. Therefore, the surveyed code is appropriately valued higher.

For additional support, the RUC referenced codes 33997 *Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion* (work RVU = 2.93 and 30 minutes intra-service time) and 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU = 2.93 and 30 minutes intra-service time) and noted these services require similar physician time and work and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 2.93 for CPT code 36466.**

**36473** ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated***
The RUC reviewed the survey results from 59 physicians and determined the current work RVU of 3.41appropriately accounts for the work required to perform this service. The specialty society expert panel reviewed the survey data and concluded that the services have not evolved in a way that would justify the increased work values at the 25$^{th}$ percentile, therefore, the specialty societies and RUC agreed that maintaining the current value was appropriate. The RUC recommends 17 minutes pre-evaluation time, 4 minutes pre-positioning time, 10 minutes scrub/dress/wait time, 30 minutes intra-service time and 11 minutes immediate post-service time, which is supported by the survey.

The RUC indicated that 3 minutes were added to positioning time to adequately adjust the patient's extremity for access to the saphenous vein and 5 minutes added to the scrub/dress/wait time as a sterile operating room technique is maintained for this procedure when performed in an office procedure/surgery suite, which requires scrubbing and sterile gown and masks and gloves for the physician and clinical staff.

CPT code 36473 uses a sclerosant agent, but instead of injecting the sclerosant as a foam, there is a device inside the vein that spins rapidly to cause spasm of that vein, which then as the physician is injecting the sclerosant, ablates the vein.

To support maintaining the current value, the RUC compared the surveyed code to the top key reference service 36482 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated* (work RVU = 3.41 and 35 minutes intra-service time) and determined that these service require the same physician work, thus are valued the same. However, noting that the surveyed code is appropriately more intense and complex as indicated by 43% of survey respondents who chose this code as the top key reference service.

The RUC compared the surveyed code to the second key reference service 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU = 3.90 and 40 minutes intra-service time) and determined that the surveyed service requires slightly less physician work and time to perform, thus is appropriately valued lower.

For additional support, the RUC referenced codes 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy;* (work RVU = 3.41 and 30 minutes intra-service time) and 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU = 3.41 and 30 minutes intra-service time) and noted these services require similar physician time and work and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 3.41 for CPT code 36473.**

**36474** ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 physicians and determined the current work RVU of 1.71 appropriately accounts for the work required to perform this add-on service. The specialty society expert panel reviewed the survey data and concluded that the services have not evolved in a way that would justify the increased work values at the 25th percentile, therefore, the specialty societies and RUC agreed that maintaining the current value was appropriate. The RUC recommends 33 minutes of intra-service time as supported by the survey.

CPT code 36474 is rarely performed as treatment of a subsequent vein in a single extremity is not typical. The RUC compared the surveyed code to the second key reference service 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 1.71 and 20 minutes intra-service time) and determined that these services require the same physician work and thus are valued the same.

For additional support, the RUC referenced codes 93464 *Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)* (work RVU = 1.76 and 30 minutes intra-service time) and 74713 *Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)* (work RVU = 1.80 and 35 minutes intra-service time) and noted these services require similar physician time and work and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.71 for CPT code 36474.**

**Practice Expense**
The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that there is "Evidence that there has been a change in equipment or practice expense cost." for the procedure. The specialty societies submitted updated invoices for two supply items, SA125 *Varithena admin pack* and SD324 *Varithena (foam*), which have increased by approximately 37% and 10%, respectively. The foam comes in an 18 milliliter canister, and 5 or 6 milliliters are used per patient. One canister is used for 3 patients, therefore, the supply unit amount entered is 0.33. The PE Subcommittee acknowledged the updated high-cost supply input, *Varithena (foam*), as recommended for CPT codes 36465 and 36466. **The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes.**

The PE Subcommittee reviewed the direct practice expense inputs and made no modifications. The PE Subcommittee Chair noted that the PE spreadsheet is organized in groups so that one can follow through the procedure. CMS requested that deleted supply items be placed adjacent to their replacements. The spreadsheet was reformatted accordingly. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

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

**Tympanostomy (Tab 20)**
**Peter Manes, MD (AAO-HNS)**

In the Proposed Rule for 2025, CMS sought comment on whether to establish an add-on payment for a service using inputs from CPT code 69433 *Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia* as a crosswalk reference, plus direct costs from invoices for the surgical devices at the request of an industry proposal to establish payment for their specific technology. CMS did not mention that a CPT Category III code already exists that may be related to this industry request. The RUC noted that CMS should not create duplicate ways to report the same procedure and should first look to CPT code 0583T *Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia.* Also, the RUC noted that if CMS was attempting to pay separately for the surgical devices mentioned, they should treat the other high-cost supply items equally. All high-cost supplies should be reported with a HCPCS code, reviewed, and priced annually, and not impact the RBRVS practice expense relative values.

However, in the Final Rule for 2025, CMS established separate payment for HCPCS code G0561 *Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (List separately in addition to 69433 (Do not use in conjunction with 0583T)* to be billed with CPT code 69433 to describe the additional resource costs associated with using the innovative tympanostomy tube delivery devices and/or systems falling under emerging technology and services categories and finalized contractor pricing for 2025.

In the Proposed Rule for 2026, CMS indicated that they received input from interested parties expressing gratitude for the creation of HCPCS code G0561 but also continuing to request that CMS establish national pricing for CPT code 0583T. In response, CMS is seeking comments on whether to nationally price both codes and what inputs for physician work, time, and direct practice expense would most accurately capture the resource costs associated with performing both procedures. For example, in response to a similar request for comment in MFS rulemaking for 2025, commenters recommended a direct crosswalk to the values associated with CPT code 31295 *Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa*, which they stated was similar to CPT code 0583T with respect to the intensity and invasiveness of the procedure, preparation time for the procedure, and total time to complete the surgery. CMS is seeking comments on whether interested parties continue to believe CPT code 31295 would be an accurate comparison or whether there are other services that CMS should consider. The RUC placed 0583T, G0561 and 69433 on this level of interest for RUC review at the January 2026 RUC meeting.

In January 2026, the specialty society did not survey or provide recommendations for CPT code 69433 *Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia* or 0583T *Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia.* For CPT code 69433, the specialty societies did not believe that the work or direct practice expense inputs have changed since it was last valued by the RUC in 2011. For code 0583T, the specialty society believes the Category III code is appropriate for tracking the use of this procedure but does not use is sufficiently widespread to warrant creation of a Category I code. The specialty society noted that 0583T was recently extended as a Category III code by industry within the past year and does not sunset within the CPT until January 2030. **The RUC did not review work or practice expense recommendations for CPT codes 69433 or 0583T for the 2027 Medicare Physician Payment Schedule since no recommendations were provided by the specialty society.**

**G0561** ***Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral***
Code G0561 is a practice expense only add-on code with a ZZZ global period, which is currently contractor priced. Code G0561 was created to allow providers to report the costs associated with performing pediatric tympanostomy procedures in an office setting using a specialized delivery device, to provide a quick, single pass to insert a tympanostomy tube system (TTS).

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. The specialty society recommended one input for the new supply item *Automated PE tube delivery device*. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

**The RUC acknowledges that CMS developed code G0561 to account for the new supply input, *Automated PE tube delivery device*. This service should not use the standard PE methodology and instead should be directly priced via an alternative PE methodology to capture only the direct costs of the individual high cost supply. Indirect costs should not be attributed to this supply only code. The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes and not price them as part of the Medicare Physician Payment Schedule.**

***Referral to CPT Assistant***
The RUC thought it would be beneficial to reiterate in coding guidance that CPT code 0583T should not be reported with CPT code 69433. CPT code 0583T is reported when performing pediatric tympanostomy in an office setting using a specialized delivery device, to provide a quick single pass to insert a tympanostomy tube system (TTS), which may be more tolerable for children. CPT code 69433 is typically reported when performing adult tympanostomy in an office setting using local anesthesia. **The RUC recommends that the specialty societies develop a CPT Assistant article reiterating that CPT code 0583T should not be reported with 69433.**

**Computed Tomography-Upper Extremity (Tab 21)**
**Michael Booker, MD (ACR), Robert Bour, MD (ACR), Andrew Moriarity, MD (ACR), Jacob Ormsby, MD (ACR)**

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 73201 via the CMS/Other source and 2023 Medicare utilization over 20,000 screen. The specialty societies indicated, and the RUC agreed for this family of services to be surveyed for the January 2026 RUC meeting.

**Compelling Evidence**
The RUC valuation of CPT code 73200 occurred in 2009, when multidetector CT was in its relative infancy. At that time, it was typical for facilities and imaging centers to possess only CT scanners that could scan no more than 4 to 16 slices at a time, limiting scanner speed and resolution. This also limited the ability to create high-quality multiplanar reconstructions with more than a limited number of slices. Now, modern CT scanners can scan 256 to 640 slices simultaneously, allowing much high-resolution imaging. This increases not only the number of images a physician must review from the acquired images, but also the number of high-resolution images in multiplanar reconstructions. It would be typical, in the time these codes were initially valued, for a physician to only have 100 or fewer images to interpret. Now, depending on the portion of the upper extremity that is scanned, this number often exceeds 1,000. CT technology continues to progress with thinner image slices, providing higher resolution images and far more images are produced per exam. Although CT scanning techniques have improved, these changes have increased physician work time and intensity.

The RUC noted that CPT codes 73201 and 73202 have never been RUC surveyed but were valued and assigned time by CMS via an unknown methodology. **The RUC determined that there is compelling evidence that the physician work has changed due to a change in technique and the knowledge/technology necessary to provide these services.**

**73200** ***Computed tomography, upper extremity; without contrast material***
The RUC reviewed the survey results from 52 radiologists and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 3 minutes pre-evaluation time, 15 minutes intra-service time and 3 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 73700 *Computed tomography, lower extremity; without contrast material* (work RVU = 0.98 and 12 minutes intra-service time) and determined the surveyed code requires slightly more time. Therefore, the surveyed code is appropriately valued higher. The RUC noted that 77% of survey respondents chose key reference service 73700 and of those respondents 80% indicated that the overall intensity and complexity is the same as the surveyed code. The survey 25th percentile work RVU of 1.00 places the surveyed code in the proper rank order when compared to the lower extremity CT without contrast reference service code.

The RUC compared the surveyed code to the second key reference service 73702 *Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.19 and 16 minutes intra-service time) and noted that, unlike 73200 which does not include contrast, CPT code 73702 is performed without contrast material followed with contrast material and further sections. The surveyed code requires slightly less physician time and work, thus, is valued slightly lower.

For additional support the RUC referenced MPC code 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered)* (work RVU = 0.88 and 15 minutes intra-service time), which is an x-ray examination that requires evaluation of less complex imaging compared to the surveyed code, whereas 73200 requires more intensity to review the anatomy. The RUC also referenced MPC code 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU = 1.25 and 15 minutes intra-service time), which is also a CT code which is appropriately valued higher than the surveyed code because of the greater complexity involving the structures of the neck and wider range of potential pathologies involved. The RUC concluded that these services appropriately bracket the surveyed service and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.00 for CPT code 73200.**

**73201** ***Computed tomography, upper extremity; with contrast material(s)***
The RUC reviewed the survey results from 53 radiologists and determined the survey 25th percentile work RVU of 1.16 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-evaluation time, 15 minutes intra-service time and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 73701 *Computed tomography, lower extremity; with contrast material(s)* (work RVU = 1.13 and 14 minutes intra-service time) and determined the surveyed code requires slightly more time and physician work. Therefore, the surveyed code is appropriately valued higher. The RUC noted that 85% of survey respondents chose

key reference service 73701 and of those respondents 78% indicated that the overall intensity and complexity is the same and 22% indicated that the overall intensity and complexity is more for the surveyed code. The survey 25th percentile work RVU of 1.16 places the surveyed code in the proper rank order when compared to the lower extremity CT with contrast reference service code.

The RUC compared the surveyed code to the second key reference service 73719 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)* (work RVU = 1.58 and 20 minutes intra-service time) and determined that the surveyed code requires slightly less physician time and work to perform, thus, is appropriately valued lower.

For additional support the RUC referenced MPC code 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered)* (work RVU = 0.88 and 15 minutes intra-service time), which is an x-ray examination that requires evaluation of less complex imaging compared to the surveyed code, whereas the surveyed code requires more intensity to review the anatomy. The RUC also referenced MPC code 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU = 1.25 and 15 minutes intra-service time), which is also
a CT code and is appropriately valued higher than the surveyed code because of the greater complexity involving the structures of the neck and wider range of potential pathologies involved. The RUC concluded that these services appropriately bracket the surveyed service and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.16 for CPT code 73201.**

**73202 *Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections***
The RUC reviewed the survey results from 43 radiologists and determined the survey 25th percentile work RVU of 1.24 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes pre-evaluation time, 20 minutes intra-service time and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 73702 *Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.19 and 16 minutes intra-service time) and determined the surveyed code requires slightly more time and physician work. Therefore, the surveyed code is appropriately valued higher. The RUC noted that 79% of survey respondents chose key reference service 73702 and of those respondents 74% indicated that the overall intensity and complexity is the same. The survey 25th percentile work RVU of 1.24 places the surveyed code in the proper rank order when compared to the lower extremity CT without contrast followed by contrast material and further sections reference service code.

The RUC compared the surveyed code to the second key reference service 73720 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.10 and 24 minutes intra-service time) and determined that the surveyed code requires slightly less physician time and work to perform, thus, is appropriately valued lower.

For additional support the RUC referenced MPC code 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered)* (work RVU = 0.88 and 15 minutes intra-service time), which is an x-ray examination

that requires evaluation of less complex imaging compared to the surveyed code, whereas 73202 requires more intensity to review the anatomy. The RUC also referenced MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.32 and 20 minutes intra-service time), which is also a CT code, which requires the same physician time and similar physician work to perform. The RUC concluded that these services appropriately bracket the surveyed service and demonstrate the appropriate relativity across the payment schedule. **The RUC recommends a work RVU of 1.24 for CPT code 73202.**

**Practice Expense**
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

**Endoluminal Coronary IVUS (Tab 22)**
**Afnan Tariq, MD (SCAI), Edward Tuohy, MD (ACC), Richard Wright, MD (ACC)**

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 92978 with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. The RAW reviewed the action plan and the RUC recommended CPT code 92978 along with the family of services be surveyed for the January 2026 RUC meeting.

**92978** ***Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 101 cardiologists and interventional cardiologists and determined the current work RVU of 1.76 appropriate accounts for the work required to perform this service. The RUC recommends 15 minutes of intra-service time as supported by the survey.

The specialty societies indicated that when IVUS was first created 30 years ago in 1996, it was typically used as a diagnostic tool, as a diagnostic imaging modality. Now it is typically used to guide endovascular interventions. Previously, the IVUS system was technologically cumbersome and time consuming to set up, image quality was poor, and the system was used infrequently, mainly for unclear or anomalous cases, and most of the procedure time was spent simply acquiring images, not on detailed analysis or intervention. Now, setup and image acquisition time have decreased due to technological advances, the process of image acquisition and analysis is more targeted, and lesions are identified and prepared with balloon pre-dilation to ease ultrasound probe passage. The typical procedure will require at least three IVUS runs during such an intervention to achieve optimal results with stenting. For the first run, data is collected and analyzed in depth, including adjusting imaging boundaries and measuring vessel specifics and the vessel is prepared as needed for stenting based on these measurements. The second run is to optimize the treatment path and modalities when the stent is placed. The third run is then conducted to measure the deployment, determine the outcome of treatment rendered and determine what, if any, additional work needs to be performed to optimize the stent. After each IVUS run, the physician must break surgical scrub to manipulate the data, analyze the data collected, and change the boundaries of the intervals to obtain better measurements. Multiple runs allow the physician to understand the trajectory of where the stent will be placed, both in the proximal and distal landing spots, and to determine what necessary further work may be needed to prepare the vessel prior to stenting.

With regards to the intensity, a rigid device is used to perform IVUS, and the physician must stretch open the vessel to allow passage of the device. Since this is larger than the typical flexible balloon wires used for procedures involving arteries, IVUS is more intense and complex to perform. The code descriptor of this service specifies that all the physician work is per artery. Regardless of the number of images captured or the number of runs conducted, this code will only be reported once per artery.

Therefore, the specialty societies indicated, and the RUC agreed that although advancements in technology and performance of IVUS have occurred, the intra-service time of 15 minutes, as indicated by the respondents, seems low and anomalous, given that a minimum of three runs are conducted to ensure proper stent placement. However, the RUC noted that the decrease in intra-service time but maintaining the work RVU appropriately represents the increase in intensity and complexity that has occurred with the evolution of these services. A higher proportion of the skin-to-skin time is now dedicated to more intense activities and interventions.

The RUC noted that the recommended work RVU of 1.76 for CPT code 92978 results in an IWPUT of 0.117. CPT code 92978 is typically reported with 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments* (work RVU = 9.75 and 60 minutes intra-service time), 68% of the time, which also a high IWPUT (0.1365). The RUC determined that the similar intensity with the service it is typically reported supports the increased intensity required to perform CPT code 92978.

The specialty societies referenced a number of services with 000-day and ZZZ global periods that support and place CPT code 92978 in the proper rank order based on intensity. Specifically, this service is placed in the proper rank order with the percutaneous coronary intervention codes, maintaining the appropriate intensity and complexity.

| Code | Description | Global | Work RVU | Intra Time | IWPUT | Total Time |
|---|---|---|---|---|---|---|
| 92941 | PCI during AMI | 000 | 12.41 | 65 | 0.1706 | 130 |
| 92937 | PCI thru bypass | 000 | 11.02 | 65 | 0.1449 | 143 |
| 92930 | Cplx Stent | 000 | 12.00 | 75 | 0.1389 | 152 |
| 92924 | Atherectomy | 000 | 9.88 | 60 | 0.1379 | 138 |
| 92920 | Angiography | 000 | 8.14 | 48 | 0.1376 | 123 |
| 92928 | Stent | 000 | 9.75 | 60 | 0.1365 | 136 |
| 92933 | Ang./Stent/Athr. | 000 | 11.64 | 75 | 0.1338 | 153 |
| 92978 | IVUS initial | ZZZ | 1.76 | 15 | 0.1173 | 15 |
| 92979 | IVUS additional | ZZZ | 1.40 | 13 | 0.1077 | 13 |
| 92945 | CTO ante/retro | 000 | 15.00 | 130 | 0.1030 | 208 |
| 92943 | CTO | 000 | 13.35 | 120 | 0.0979 | 198 |
| 92972 | IVL | ZZZ | 2.90 | 30 | 0.0967 | 30 |
| 93571 | FFR Initial | ZZZ | 1.76 | 20 | 0.0880 | 20 |
| 93572 | FFR additional | ZZZ | 1.40 | 16 | 0.0875 | 20 |
| 92973 | Thrombectomy | ZZZ | 1.71 | 20 | 0.0855 | 20 |

The RUC compared the surveyed code to the top key reference service 37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.76 and 20 minutes intra-service time) and determined that these services typically require the same physician work and thus are valued the same.

The RUC compared the surveyed code to the second top key reference service 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 primary procedure)* (work RVU = 2.44 and 20 minutes intra-service time). Of the survey respondents who chose CPT code 33370 as the key reference service, 78% indicated that the surveyed code is more intense and complex to perform overall. The RUC determined that the surveyed code is slightly more intense and complex to perform but requires slightly less time and physician work. Thus, the surveyed code is appropriately valued lower than CPT code 33370.

During discussion, the RUC referenced comparable service 67331 *Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)* (work RVU = 1.95 and 15 minutes intra-service time), which requires comparable physician time and work to perform.

For additional support the RUC referenced MPC code 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 = 2.04 and 15 minutes intra-service time) to demonstrate the appropriate relativity across the payment schedule. The RUC concluded that the value of CPT code 92978 should be maintained at 1.76 work RVUs. **The RUC recommends a work RVU of 1.76 for CPT code 92978.**

**92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 102 cardiologists and interventional cardiologists and determined the current work RVU of 1.40 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of intra-service time as supported by the survey. CPT code 92979 describes IVUS performed on a second vessel. The physician may be switching from the left coronary to the right coronary, but basically, the difference compared to 92978 is to rewire an additional vessel. The IVUS system is already prepped, the physician flushes the catheter again and then starts reimaging. The remaining work is the same as 92978.

The specialty societies indicated that when IVUS was first created 30 years ago in 1996, it was typically used as a diagnostic tool, as a diagnostic imaging modality. Now it is typically used to guide endovascular interventions. Previously, the IVUS system was technologically cumbersome and time consuming to set up, image quality was poor, and the system was used infrequently, mainly for unclear or anomalous cases, and most of the procedure time was spent simply acquiring images, not on detailed analysis or intervention. Now, setup and image acquisition time have decreased due to technological advances, the process of image acquisition and analysis is more targeted, and lesions are identified and prepared with balloon pre-dilation to ease ultrasound probe passage. The typical procedure will require at least three runs during such an intervention to achieve optimal results with stenting. For the first run, data is collected and analyzed in depth, including adjusting imaging

boundaries and measuring vessel specifics and the vessel is prepared as needed for stenting based on these measurements. The second run is to optimize the treatment path and modalities when the stent is placed. The third run is then conducted to measure the deployment, determine the outcome of treatment rendered and determine what, if any, additional work needs to be performed to optimize the stent. After each run, the physician must break surgical scrub to manipulate the data, analyze the data collected, and change the boundaries of the intervals to obtain better measurements. Multiple runs allow the physician to understand the trajectory of where the stent will be placed, both in the proximal and distal landing spots, and to determine what necessary further work may be needed to prepare the vessel prior to stenting.

With regards to the intensity, a rigid device is used to perform IVUS, and the physician must stretch open the vessel to allow passage of the device. Since this is larger than the typical flexible balloon wires used for procedures involving arteries, IVUS is more intense and complex to perform. The code descriptor of this service specifies that all the physician work is per artery. Regardless of the number of images captured or the number of runs conducted, this code will only be reported once, no matter how many times IVUS is conducted in a particular artery.

Therefore, the specialty societies and the RUC agreed that although advancements in technology and performance of IVUS have occurred, the intra-service time of 13 minutes as indicated by the survey respondents seems low and anomalous, given that a minimum of three runs are conducted to ensure proper stent placement. However, the RUC noted that the decrease in intra-service time but maintaining the work RVU appropriately represents the increase in intensity and complexity that has occurred with the evolution of these services. A higher proportion of the skin-to-skin time is now dedicated to more intense activities and interventions.

The RUC noted that the recommended work RVU of 1.40 for CPT code 92979 results in an IWPUT of 0.108. CPT code 92979 is typically reported with 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments* (work RVU = 9.75 and 60 minutes intra-service time) 73.1% of the time, which also a high IWPUT (0.1365). The RUC determined that the similar intensity with the service it is typically reported supports the increased intensity required to perform CPT code 92979.

The specialty societies referenced a number of services with 000-day and ZZZ global periods that support and place CPT code 92979 in the proper rank order based on intensity. Specifically, this service is placed in the proper rank order with the percutaneous coronary intervention codes, maintaining the appropriate intensity and complexity.

| Code | Description | Global | Work RVU | Intra Time | IWPUT | Total Time |
|---|---|---|---|---|---|---|
| 92941 | PCI during AMI | 000 | 12.41 | 65 | 0.1706 | 130 |
| 92937 | PCI thru bypass | 000 | 11.02 | 65 | 0.1449 | 143 |
| 92930 | Cplx Stent | 000 | 12.00 | 75 | 0.1389 | 152 |
| 92924 | Atherectomy | 000 | 9.88 | 60 | 0.1379 | 138 |
| 92920 | Angiography | 000 | 8.14 | 48 | 0.1376 | 123 |
| 92928 | Stent | 000 | 9.75 | 60 | 0.1365 | 136 |
| 92933 | Ang./Stent/Athr. | 000 | 11.64 | 75 | 0.1338 | 153 |
| 92978 | IVUS initial | ZZZ | 1.76 | 15 | 0.1173 | 15 |
| 92979 | IVUS additional | ZZZ | 1.40 | 13 | 0.1077 | 13 |
| 92945 | CTO ante/retro | 000 | 15.00 | 130 | 0.1030 | 208 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 92943 | CTO | 000 | 13.35 | 120 | 0.0979 | 198 |
| 92972 | IVL | ZZZ | 2.90 | 30 | 0.0967 | 30 |
| 93571 | FFR Initial | ZZZ | 1.76 | 20 | 0.0880 | 20 |
| 93572 | FFR additional | ZZZ | 1.40 | 16 | 0.0875 | 20 |
| 92973 | Thrombectomy | ZZZ | 1.71 | 20 | 0.0855 | 20 |

The RUC compared the surveyed code to the top key reference service 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.40 and 20 minutes intra-service time) and determined that these services require the same physician work and thus are valued the same. Over half of the survey respondents chose CPT code 37253 as the top key reference service, and 76% indicated that the surveyed code is overall more intense and complex to perform. Thus, supports the lower intra-service time but higher intensity required to perform CPT code 92979.

The RUC compared the surveyed code to the second top key reference service 37252 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.76 and 20 minutes intra-service time) and determined that the surveyed service requires slightly less physician work and time, thus is appropriately valued lower.

During discussion, the RUC referenced comparable service 58611 *Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)* (work RVU = 1.41 and 13.5 minutes intra-service time), which requires comparable physician time, work and intensity to perform. The RUC concluded that the value of CPT code 92979 should be maintained at 1.40 work RVUs. **The RUC recommends a work RVU of 1.40 for CPT code 92979.**

**Practice Expense**
**The RUC recommends no direct practice expense inputs for CPT codes 92978 and 92979 as they are facility-only services.**

**RUC Database Flag**
The specialty societies and the RUC questioned the accuracy of the intra-service times as indicated by the survey respondents. The RUC determined the survey respondents underestimated the intra-service time since the vessel will typically be entered at least three times, but the respondents indicated times of 15 and 13 minutes to perform 92978 and 92979, respectively, which was considered low. **The RUC recommends to flag CPT codes 92978 and 92979 as *Do Not Use to Validate Physician Work - Anomalous intra-service time*.**

**<u>Transesophageal Echocardiography (Tab 23)</u>**
**Gordon Morewood, MD (ASA), Edward Tuohy, MD (ACC), Richard Wright, MD (ACC)**

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 93355 with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. The RAW reviewed the action plan and the RUC recommended CPT code 93355 be surveyed for the January 2026 RUC meeting.

At the January 2026 meeting, the specialty societies requested that CPT code 93355 be referred to the CPT May 2026 meeting to create a more granular framework to capture physician work and role delineation across practice settings (i.e., interventional imagers, structural heart operators and anesthesiology teams). The specialty societies believe the service has changed and the current code no longer represents how interventional transesophageal echocardiography (TEE) is currently performed. **The RUC agreed and recommends that CPT code 93355 be referred to CPT for the May 2026 CPT Editorial Panel meeting.**

**Continuous Glucose Monitoring (Tab 24)**
**William Biggs, MD (AACE), Chase Hendrickson, MD (ES), Carrie Kerby, MSN (ANA), Michael Morkos, MD (AACE)**

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 95251 with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. The RAW reviewed the action plan and the RUC recommended that CPT code 95251 along with the family of services be surveyed for the January 2026 RUC meeting.

In January 2026, the specialty societies requested that the continuous glucose monitoring codes (95249, 95250 and 95251) be referred to the CPT Editorial Panel to be revised to reflect the advances in diabetes technology. The major change in technology is how the continuous glucose monitoring devices interact and work with insulin pumps. **The RUC recommends CPT codes 95249, 95250 and 95251 be referred to the September 2026 CPT Editorial Panel meeting.**

## X. Research Subcommittee (Tab 25)

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

The Research Subcommittee did not have a separate general policy meeting which coincided with the January 2026 RUC meeting. The Subcommittee last met on October 6, 2025, to review specialty society requests pertaining to RUC surveys for the January 2026 meeting. On the October 6, 2025 call, the Research Subcommittee reviewed and approved proposed vignettes, custom survey templates, draft reference service lists and targeted survey sample methodology requests.

The Subcommittee also updated its *Research Subcommittee Guidelines & Requirements* document to include additional exceptions for its survey sample methodology approval requirement. Specifically, use of a random sample from a society without representation on the RUC Advisory Committee does not require Research Subcommittee approval, provided that this non-RUC society list is accompanied by random sample of each participating specialty society that is on the RUC Advisory Committee. Also, societies may include a targeted sample of physicians/QHPs that perform a service by identifying those individuals using publicly available Medicare claims data without Research Subcommittee approval, provided that this targeted list is accompanied by random sample of each participating society's membership.

**The RUC approved the Research Subcommittee Report.**

## XI. Practice Expense Subcommittee (Tab 26)

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

*Moderate Sedation Pack (SA044) Modifications*
At the September 2025 meeting, the PE Subcommittee considered two tabs performed with moderate sedation, Tab 05 *Intraosseous Fiducial Marker Placement* and Tab 07 *Sacroiliac Joint Arthrodesis*. This requires review for duplicate PE inputs; in doing so, the Subcommittee questioned the rationale for including a sterile gown but no mask in the moderate sedation pack (SA044). The PE Subcommittee expressed the need to understand the background related to the formation of this pack. Accordingly, at the January 2026 RUC meeting, the RUC discussed the creation and composition of the moderate sedation pack. The pack was first created by the RUC in 2001 and re-examined by its Direct Input Expense for Moderate Sedation Workgroup in 2010-2011. CMS finalized SA044 *pack, moderate sedation* for the 2012 Medicare Physician Payment Schedule. The sterile surgical gown was included in the moderate sedation pack from the onset in 2001 without mention of a mask.

The PE Subcommittee determined, and the RUC agreed, that the sterile gown is not needed as part of the moderate sedation pack. At the RUC meeting, a regular staff gown was added to acknowledge standard universal precautions to protect the sedation provider from all body fluids, substance, and excretions. The RUC also agreed that, although a mask has not been part of the pack, this would be an appropriate addition. The PE Subcommittee report recommendation was amended to read as follows:

**The RUC requests that CMS modify the SA044 *pack, moderate sedation* to replace SB028 *gown, surgical, sterile* with SB027 *gown, staff, impervious* and add a SB033 *mask, surgical*. [The current price of the pack is $19.20 - $5.13 sterile gown + $1.19 staff gown + $0.43 mask = $15.69 revised total for SA044.]**

*Equipment Repricing Dates*
At the January 2026 RUC meeting, it was suggested that CMS add a date indicating when equipment items were last repriced. The RUC agreed that this information would be useful to specialties as they prepare their recommendations.

**The RUC requests that CMS add the date of the last repricing to the inputs in the CMS equipment item file.**

**The RUC approved the Practice Expense Subcommittee Report.**

## XII. Health Care Professionals Advisory Committee (HCPAC) Review Board (Tab 27)

Leisha Eiten, AuD, Co-Chair, provided the Health Care Professionals Advisory Committee (HCPAC) Review Board report to the RUC.

**Relative Value Recommendations for CPT 2027**

**A. Biofeedback Training (90901, 90X03)**
**Beth Ackerman, PT (APTA), Stephen Gillaspy, PhD (APA psychology), Carrie Kerby, MSN (ANA), Angela Pennisi, PT, DPT (APTA), Richard Rausch, DPT (APTA), Scott Sperling, PsyD (APA psychology)**

In April 2023, the Relativity Assessment Workgroup (RAW) identified CPT code 90901 via the high-volume growth screen with 2021 Medicare utilization of 10,000 or more than increased by at least 100% from 2016 through 2021. In September 2023, the RAW reviewed the action plan for CPT code 90901 and agreed with the specialty societies that 90901, along with the other services in this code family (90912 and 90913) should be surveyed for the April 2024 RUC meeting. However, when the specialty societies were preparing to survey the services, they determined they could not proceed and instead requested to revise the code family through the CPT process before surveying. The specialty societies noted that the current code descriptor for CPT code 90901 was not well understood based on their review of past RUC rationales for valuation, claims data, and the vignettes used for review in 1995 and 1996 by the RUC and HCPAC. In the 1995 RUC rationale, the vignette described 45–60-minute sessions (and brief 30-minute sessions) and included information about psychiatrists and psychologists, though it is unclear who was surveyed. Additionally, the 1996 RUC rationale of the HCPAC review is based on a different vignette and was surveyed by physical therapists, which led to a reduction of the work RVU from 0.89 to 0.41 based on comparison to a time-based therapy code, CPT code 97110. The specialty societies note that although legacy version of 90901 was not time-based, the comparison for the current value was to a 15-minute time-based code despite the current intra-service time being 45 minutes.

In their letter to request a referral to CPT for this code family, the specialty societies proposed revising the code descriptor for CPT code 90901 to be consistent with other physical therapy time-based and modality codes, as well as similar to other biofeedback training codes. Additionally, code descriptor clarification may resolve the continued confusion about the intent and correct coding for 90901. The RUC recommended that CPT codes 90901, 90912 and 90913 be referred to the CPT Editorial Panel meeting for revision. In September 2025, the CPT Editorial Panel revised code 90901 to describe the initial 15 minutes of biofeedback training by a physician or other qualified health care professional with direct patient contact and created one new code (90X03) to describe each additional 15 minutes. CPT codes 90912 and 90913 were added as family. **CPT codes 90912 and 90913 were surveyed for the January 2026 RUC meeting. CPT codes 90901 and new code 90X03 were surveyed for the January 2026 RUC HCPAC Review Board meeting.**

**Compelling Evidence**
The specialty societies presented compelling evidence based on an anomalous relationship given that the relative value for CPT Code 90901 is inappropriately valued based on a direct comparison to CPT code 97110.

In 1996, the HCPAC recommended a reduction in the work RVU from 0.89 to 0.45 for CPT code 90901 *Biofeedback training by any modality*. The HCPAC stated "90901 is similar in work to 97110 *Therapeutic procedure; one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range or motion or flexibility*" and thus recommended the work RVU of 0.45 for 90901. The 90901 work time referenced by the HCPAC was 5 minutes pre-service, 45 minutes intra-service and 10 minutes post-service time, totaling 60 minutes. However, CPT Code 97110 was a time-based code, 15 minutes, (5 minutes pre-service, 15 minutes intra-service, 5 minutes post-service, totaling 25 minutes). CPT code 90901 described a service that required more work than 97110 but nevertheless was valued the same. **The RUC HCPAC Review Board accepted compelling evidence based on an anomalous relationship between CPT codes 90901 and 97110.**

**90901** ***Biofeedback training by any modality (eg, EMG, EEG, ECG); initial 15 minutes of direct patient contact by physician or other qualified health care professional***
The RUC HCPAC reviewed the survey results from 46 physical therapists and psychologists and recommends a work RVU of 0.61 based on the survey 25$^{th}$ percentile, which maintains relativity

within the family for this code. The RUC HCPAC recommends 7 minutes of pre-service evaluation time, 15 minutes intra-service time, and 5 minutes immediate post-service time.

For this procedure, the qualified health care professional (QHP) inspects and prepares the skin for electrode placement and then reads responses simultaneously with patient monitoring to control/change muscle responses. At the end of the treatment, the QHP removes the electrodes and inspects the skin.
To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service codes 97112 *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities* (work RVU = 0.50 and 15 minutes intra-service time) and 96158 *Health behavior intervention, individual, face-to-face; initial 30 minutes* (work RVU = 1.66 and 30 minutes intra-service time). A majority of the survey respondents that selected the top key reference codes indicated that the surveyed code is more intense/complex. The surveyed code intra-service time is identical to the first key reference service; however, the total time is higher, appropriately supporting the recommended work RVU. Therefore, the recommended work RVU is appropriately bracketed by the key reference services.

For additional support, the RUC HCPAC referenced MPC code 20600 *Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance* (work RVU = 0.64 and 5 minutes intra-service time). The surveyed code is appropriately valued at 0.61 in comparison to 20600. **The RUC HCPAC recommends a work RVU of 0.61 for CPT code 90901.**

**90X03** ***Biofeedback training by any modality (eg, EMG, EEG, ECG); each additional 15 minutes of direct patient contact by physician or other qualified health care professional (List separately in addition to code for primary procedure)***
The RUC HCPAC reviewed the survey results from 34 physical therapists and psychologists and recommends a work RVU of 0.48 based on a direct crosswalk to CPT code 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48 and 15 minutes intra-service time), which maintains relativity within the family for this code. The RUC HCPAC recommends 16 minutes intra-service time. This add-on code is expected to be reported together with the base code 30% of the time and 2 units are anticipated.

For this procedure, the qualified health care professional (QHP) continues treatment by reading responses simultaneously with patient monitoring to control/change muscle responses.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the second key reference service code 96159 *Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.57 and 15 minutes intra-service time). A majority of the survey respondents that selected the second key reference code indicated that the surveyed code is more intense/complex to perform. That said, the surveyed code intensity/complexity is lower than the second key reference service, albeit the intra-service and total time being slightly higher, supporting the recommended work RVU of the surveyed code.

For additional support, the RUC HCPAC referenced 97112 *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities* (work RVU = 0.50 and 15 minutes intraservice time). The surveyed code has identical intra-service time and slightly lower total time suggesting that the recommended work RVU is appropriately lower for the surveyed code. **The RUC HCPAC recommends a work RVU of 0.48 for CPT code 90X03.**

**Practice Expense**
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications to CPT codes 90901 and 90X03. The PE Subcommittee noted the addition of a new supply item, *disposble paper shorts*, for 90901 as the typical patient engaging in biofeedback for a post-operative lower extremity procedure, paper shorts are the standard. CMS inquired about equipment input EF031 *table, power* where the specialties are recommending a power table instead of the EF023 *table, exam* previously included in CPT code 90901. A power table is typical for the PT office and is necessary for getting the patient into positions for biofeedback services. As noted in the majority of CPT codes in the PM&R section (e.g. 97110, 97112, 97116, 97162), a power table is the standard equipment. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

**Referral to the CPT Editorial Panel**
The HCPAC Review Board recommends CPT codes 90901 and 90X03 be referred to the CPT Editorial Panel to review an editorial change related to the CPT code 90901 and 90X03 code descriptor language "(eg, EMG, EEG, ECG)" to clarify that the services noted are not separately reportable.

**B. Speech-Language Pathology Services (92X0X, 92X1X, 92X2X, 92X3X, 92X4X, 92X5X, 92X6X, 92X7X, 92X8X, 92X9X, 92508)**
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In April 2024, CPT code 92507 was identified via the high-volume growth screen, with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. In 2017, Medicare utilization for 92507 reflected 245,131 claims, and the most recent 2024 data for 92507 reflect 819,853 claims. The Relativity Assessment Workgroup (RAW) requested that the specialty societies submit an action plan for codes for September 2024. In September 2024, the RUC accepted the specialty society recommendation to refer to CPT to reflect current practice patterns and modernize the descriptions of treatment services currently captured under CPT code 92507. At the September 2025 CPT Editorial Panel meeting, CPT code 92507 was replaced with 10 new codes to report fluency disorder, speech sound production disorder, language comprehension and expression disorder, speech sound production disorder and language comprehension and expression disorder, and voice, upper airway dysfunction and/or resonance disorders. Additionally, the introductory guidelines were revised to clarify reporting of the services. The code family was surveyed for the January 2026 RUC HCPAC Review Board meeting.

**Compelling Evidence**
The specialty societies presented compelling evidence to support a change in physician or other qualified healthcare professional (QHP) work due to changes in technique and knowledge/technology since CPT code 92507 was created over 20 years ago. These new codes will replace the legacy code 92507 which was last surveyed more than 15 years ago in 2010. Since then, there have been significant changes to practice patterns, especially in the areas of technology, knowledge, and techniques available to clinicians. The availability of new technologies, fueled by advances in

research, has allowed for an increase in clinician's knowledge base and has modernized the practice patterns to provide more specialized treatment using new techniques.

Specifically, CPT code 92507 formerly included a broad range of treatment types, whereas now these services will be described and differentiated under this new code family. Although 92507 was a single comprehensive code, it was rarely used in practice to represent multiple treatment procedures delivered in the same session. It is uncommon in actual clinical practice for a single session to address all of the areas described under 92507 concurrently. Typically, only one type of treatment is provided and reported under this code. Thus, historically 92507 already represents the work associated with individual therapy procedures now described under new codes 92X0X-92X9X, rather than the sum of these separate procedures.

Deleted CPT code 92507, currently used to report a wide range of speech-language pathology services, was overly broad and lacks the specificity needed to reflect modern clinical practice. This code does not accurately capture the distinct clinical needs and therapeutic approaches required to treat the diverse disorders it encompasses. The new codes offer greater specialization and precision, describing differentiated services that rely on multi-modality therapeutic techniques. Since the development of this code, clinical practice patterns have evolved significantly, along with the technology, equipment, and supplies used in treatment. Additionally, research in these distinct areas has expanded, enabling clinicians to provide treatments that are increasingly targeted, evidence-based, and tailored to each disorder. These advancements require unique skills and specialized tools that CPT code 92507 does not adequately represent.

**The RUC HCPAC Review Board accepted compelling evidence based on a change in physician/QHP work, technique, and knowledge/technology. The budget neutrality calculations using the assumptions articulated by the specialty societies and the revised recommendations by the RUC HCPAC Review Board demonstrate that this code family is budget neutral.**

**Anticipated Code Reporting Patterns Utilized for Work Neutrality Calculation**
To determine budget/work neutrality, a few assumptions were made regarding code reporting patterns. The HCPAC noted that the RAW will review an action plan if the first year of utilization indicates that these assumptions were incorrect. For this code family, the base CPT codes 92X0X, 92X2X, 92X4X, 92X6X, and 92X8X are expected to be reported alone 75% of the time. It is anticipated that the add-on codes will be reported with a base code 25% of the time. For CPT add-on codes 92X1X, 92X3X, 92X5X, and 92X9X, two units of the add-on code are expected to be reported when additional treatment time is needed. CPT add-on code 92X7X differs slightly as it is for a patient being treated for two interdependent impairments simultaneously; therefore, when additional time is needed, 3 units of the add-on code are expected. For this family, the base codes and the respective add-on codes are not anticipated to be reported with other services more than 50% of the time based on the reported together data for CPT code 92507. The 2024 Medicare utilization data for 92507 indicates that the code is reported alone 77% of the time, which supports the expected reporting patterns.

**92X0X** ***Treatment of fluency disorder (eg, stuttering and cluttering), direct (one-on-one) patient contact; initial 30 minutes***
The RUC HCPAC reviewed the survey results from 66 speech-language pathologists and recommends a work RVU of 0.92 based on the survey median, which maintains relativity within the family for this code. The RUC HCPAC recommends 5 minutes of pre-service evaluation time, 30 minutes intra-service time, and 5 minutes post-service time.

The treatment of fluency disorder requires a high level of clinical complexity, cognitive workload, and a high level of professional engagement. Fluency disorder treatment is highly dynamic, requiring continuous assessment and adjustment based on the patient's behaviors and responses. The QHP must integrate behavioral observations, employ evidence-based fluency-shaping and tension-reduction techniques, and use technology-assisted speech analysis to interpret dysfluency patterns and deliver real-time feedback. Engaging both patients and caregivers in strategy acquisition and carryover further underscores the complexity and expertise required.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to CPT codes 92584 *Electrocochleography* (work RVU = 0.98 and 30 minutes intra-service time) and 92651 *Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report* (work RVU = 0.98 and 30 minutes intra-service time). These codes are valid comparators as they involve a similar amount of QHP work. The referenced CPT codes have more total time and identical intra-service time, suggesting that the surveyed code recommended work RVU is appropriately lower than the reference codes.

For additional support, the RUC HCPAC referenced CPT code 97550 *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes* (work RVU = 1.00 and 30 minutes intra-service time). The surveyed code intra-service and the total time are identical, suggesting that the codes should be valued similarly. **The RUC HCPAC recommends a work RVU of 0.92 for CPT code 92X0X.**

**92X1X** ***Treatment of fluency disorder (eg, stuttering and cluttering), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary service)***
The RUC HCPAC reviewed the survey results from 57 speech-language pathologists and recommends a work RVU of 0.44 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this add-on service. The RUC HCPAC recommends 17 minutes of intra-service time.

When additional treatment time beyond the first 30 minutes is needed, the intensity of professional work does not simply increase linearly with time. Longer treatment durations reflect greater clinical demands, including managing patient fatigue, adapting strategies in real time, addressing more complex behavioral patterns, and sustaining a high level of therapeutic engagement. The QHP must continuously modulate techniques, monitor physiologic and behavioral cues, and recalibrate interventions to maintain treatment effectiveness. This escalation in cognitive load and decision-making justifies the 25$^{th}$ percentile work RVU for the add-on code.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service code 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48 and 15 minutes intra-service time). The surveyed code recommended work RVU is appropriately lower when compared to the reference code given the lower intensity/complexity to perform the service, albeit the higher intra-service and total time.

For additional support, the RUC HCPAC referenced MPC code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45 and 15 minutes intra-service time). This code is a valid comparator as the intra-service and total time are identical, suggesting that the codes should be valued similarly. Additionally, MPC code 97530 *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes* (work RVU = 0.44 and 15 minutes intra-service time) is an excellent comparator, which has similar times to the surveyed code, and therefore, the surveyed code should be valued similarly to the MPC code. **The RUC HCPAC recommends a work RVU of 0.44 for CPT code 92X1X.**

**92X2X *Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria), direct (one-on-one) patient contact; initial 30 minutes***
The RUC HCPAC reviewed the survey results from 83 speech-language pathologists and recommends a work RVU of 0.90 based on the survey median, which maintains relativity within the family for this code. The RUC HCPAC recommends 5 minutes of pre-service evaluation time, 30 minutes intra-service time, and 5 minutes post-service time.

The treatment of speech and sound disorders requires a high level of clinical complexity, cognitive workload, and a high level of professional engagement. Intervention targets multiple motor speech subsystems simultaneously, including respiration, phonation, articulation, resonance, and prosody. The QHP must continuously analyze the patient's performance and adjust strategies to improve breath support, voice quality, articulatory precision, and speech intelligibility. Advanced tools such as software-based speech analysis, video monitoring, and EMG biofeedback add further cognitive demands by requiring interpretation of physiologic and acoustic data to guide treatment modifications.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to CPT codes 92584 *Electrocochleography* (work RVU = 0.98 and 30 minutes intra-service time) and 92651 *Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report* (work RVU = 0.98 and 30 minutes intra-service time). These codes are valid comparators as they are valued similarly. The reference CPT codes have more total time and identical intra-service time, suggesting that the surveyed code recommended work RVU is appropriately lower than the reference codes.

For additional support, the RUC HCPAC referenced CPT code 97550 *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes* (work RVU = 1.00 and 30 minutes intra-service time). The surveyed code intra-service and the total time are identical, suggesting that the codes should be valued similarly. **The RUC HCPAC recommends a work RVU of 0.90 for CPT code 92X2X.**

**92X3X *Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary service)***
The RUC HCPAC reviewed the survey results from 77 speech-language pathologists and recommends a work RVU of 0.44 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this add-on service. The RUC HCPAC recommends 17 minutes of intra-service time.

When additional treatment time beyond the first 30 minutes is needed, the intensity of professional work does not simply increase linearly with time. Longer treatment durations reflect greater clinical demands, including managing patient fatigue, adapting strategies in real time, addressing more complex behavioral patterns, and sustaining a high level of therapeutic engagement. The QHP must continuously modulate techniques, monitor physiologic and behavioral cues, and recalibrate interventions to maintain treatment effectiveness. This escalation in cognitive load and decision-making justifies the 25th percentile work RVU for the add-on code.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service code 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48 and 15 minutes intra-service time). The surveyed code recommended work RVU is appropriately lower when compared to the reference code given the lower intensity/complexity to perform the service, albeit the higher intra-service and total time.

For additional support, the RUC HCPAC referenced MPC code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45 and 15 minutes intra-service time). This code is a valid comparator as the intra-service and total time are identical, suggesting that the codes should be valued similarly. Additionally, MPC code 97530 *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes* (work RVU = 0.44 and 15 minutes intra-service time) is a valid comparator, which has similar times to the surveyed code, and therefore, the surveyed code should be valued similarly to the MPC code. **The RUC HCPAC recommends a work RVU of 0.44 for CPT code 92X3X.**

**92X4X *Treatment of language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; initial 30 minutes***
The RUC HCPAC reviewed the survey results from 84 speech-language pathologists and recommends a work RVU of 1.00 based on the survey median, which maintains relativity within the family for this code. The RUC HCPAC recommends 5 minutes of pre-service evaluation time, 34 minutes intra-service time, and 5 minutes post-service time.

The treatment of language disorder requires a high level of clinical complexity, cognitive workload, and a high level of professional engagement. This service addresses complex receptive and expressive language deficits, which are often acquired as a result of stroke, traumatic brain injury, neurodegenerative disease, or other medically complex conditions. Expressive language intervention demands continuous clinical judgment as the QHP selects and adapts strategies to improve word retrieval, sentence formulation, and written language production, progressing from simple to increasingly complex tasks based on the patient's real-time performance. Receptive language treatment similarly requires nuanced adjustments to target listening and reading comprehension, direction-following, and interpretation of figurative and written language. For medically complex patients, these tasks must be adapted to account for cognitive load, processing speed, visual or auditory limitations, and fatigue.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to CPT codes 92584 *Electrocochleography* (work RVU = 0.98 and 30 minutes intra-service time) and 92651 *Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report* (work RVU = 0.98 and 30 minutes intra-service time). These codes are valid comparators

as they are valued similarly. The reference CPT codes have similar intra-service and total times, suggesting that the surveyed code should be valued similarly.

For additional support, the RUC HCPAC referenced CPT code 97550 *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes* (work RVU = 1.00 and 30 minutes intra-service time). The surveyed code intra-service and the total time are slightly higher, albeit similar to the reference code, suggesting that they should be valued similarly. **The RUC HCPAC recommends a work RVU of 1.00 for CPT code 92X4X.**

**92X5X *Treatment of language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary service)***
The RUC HCPAC reviewed the survey results from 77 speech-language pathologists and recommends a work RVU of 0.48 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this add-on service. The RUC HCPAC recommends 20 minutes of intra-service time.

When additional treatment time beyond the first 30 minutes is needed, the intensity of professional work does not simply increase linearly with time. Longer treatment durations reflect greater clinical demands, including managing patient fatigue, adapting strategies in real time, addressing more complex behavioral patterns, and sustaining a high level of therapeutic engagement. The QHP must continuously modulate techniques, monitor physiologic and behavioral cues, and recalibrate interventions to maintain treatment effectiveness. This escalation in cognitive load and decision-making justifies the 25$^{th}$ percentile work RVU for the add-on code.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service code 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48 and 15 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported by the key reference service, given the lower intensity/complexity to perform the service, albeit the higher intra-service and total time.

For additional support, the RUC HCPAC referenced MPC code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45 and 15 minutes intra-service time). This code is a valid comparator as the intra-service and total time are slightly lower when compared to the surveyed code, suggesting that the surveyed code recommended work RVU is appropriately higher. Additionally, MPC code 97533 *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes* (work RVU = 0.48 and 15 minutes intra-service time) is a valid comparator, which has similar total time to the surveyed code, and therefore, the surveyed code should be valued similarly to the MPC code. **The RUC HCPAC recommends a work RVU of 0.48 for CPT code 92X5X.**

**92X6X** ***Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria) and language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; initial 30 minutes***
The RUC HCPAC reviewed the survey results from 82 speech-language pathologists and recommends a work RVU of 1.00 based on the survey median, which maintains relativity within the family for this code. The RUC HCPAC recommends 5 minutes of pre-service evaluation time, 33 minutes intra-service time, and 3 minutes post-service time.

The treatment of speech and language disorders requires a high level of clinical complexity, cognitive workload, and a high level of professional engagement. Treating a patient with co-occurring speech and language disorders requires the QHP to manage multiple, interdependent impairments simultaneously. The clinician must address motor speech production (e.g., articulatory placement, breath–voice coordination) while also targeting language skills such as vocabulary, comprehension, and sentence formulation. Because difficulties in one domain directly influence performance in the other, the clinician engages in continuous real-time assessment and modification of therapeutic strategies. The session involves interpreting subtle behavioral and linguistic cues, maintaining developmentally appropriate engagement, and selecting or shifting among specialized tools, stimuli, and feedback systems as the patient's needs evolve moment to moment. The clinician must also translate these gains into functional communication by developing individualized home strategies and training caregivers.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to CPT codes 92584 *Electrocochleography* (work RVU = 0.98 and 30 minutes intra-service time) and 92651 *Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report* (work RVU = 0.98 and 30 minutes intra-service time). These codes are valid comparators as they are valued similarly. The reference CPT codes have similar intra-service time and total times, suggesting that the surveyed code should be valued similarly.

For additional support, the RUC HCPAC referenced CPT code 97550 *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes* (work RVU = 1.00 and 30 minutes intra-service time). The surveyed code intra-service and the total time are slightly higher, albeit similar to the reference code, suggesting that they should be valued similarly. **The RUC HCPAC recommends a work RVU of 1.00 for CPT code 92X6X.**

**92X7X** ***Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria) and language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary service)***
The RUC HCPAC reviewed the survey results from 77 speech-language pathologists and recommends a work RVU of 0.50 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this add-on service. The RUC HCPAC recommends 22 minutes of intra-service time. The RUC agreed with the specialty society to adjust the survey median intra-service time from 23 minutes to 22 minutes, which is within the 8-22 minute range required to report a 15-minute code as required by the CPT coding guidelines.

When additional treatment time beyond the first 30 minutes is needed, the intensity of professional work does not simply increase linearly with time. Longer treatment durations reflect greater clinical demands, including managing patient fatigue, adapting strategies in real time, addressing more

complex behavioral patterns, and sustaining a high level of therapeutic engagement. The QHP must continuously modulate techniques, monitor physiologic and behavioral cues, and recalibrate interventions to maintain treatment effectiveness. This escalation in cognitive load and decision-making justifies the median work RVU for the add-on code, especially in a session where the QHP is managing multiple, interdependent impairments simultaneously.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service code 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48 and 15 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported by the key reference service given the higher intra-service and total time, although the lower intensity/complexity to perform the service.

For additional support, the RUC HCPAC referenced MPC code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45 and 15 minutes intra-service time). The MPC code intra-service and total time are slightly lower when compared to the surveyed code, suggesting that the surveyed code recommended work RVU is appropriately higher. Additionally, MPC code 97533 *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes* (work RVU = 0.48 and 15 minutes intra-service time) is a valid comparator which has similar total time, although the surveyed code has higher intra-service time, supporting the slightly higher work RVU. **The RUC HCPAC recommends a work RVU of 0.50 for CPT code 92X7X.**

**92X8X *Treatment of voice, upper airway dysfunction, and/or resonance disorders, direct (one-on-one) patient contact; initial 30 minutes***
The RUC HCPAC reviewed the survey results from 63 speech-language pathologists and recommends a work RVU of 0.98 based on a direct crosswalk to CPT code 92584 *Electrocochleography* (work RVU = 0.98 and 30 minutes intra-service time), which maintains relativity within the family for this code. The RUC HCPAC recommends 5 minutes of pre-service evaluation time, 33 minutes intra-service time, and 5 minutes post-service time.

Voice therapy for patients with vocal impairment involves considerable clinical complexity. The QHP must simultaneously address respiratory support, airflow management, phonatory efficiency, laryngeal tension, and resonance, each of which directly affects vocal function. Treatment requires real-time assessment and adjustment as the QHP employs evidence-based techniques such as respiratory retraining, postural optimization, laryngeal relaxation (including manual techniques), and resonance rebalancing. Advanced software and phonatory analysis systems are used to provide immediate acoustic and physiologic feedback, allowing the QHP to refine therapeutic strategies moment to moment. Because vocal deficits often stem from complex medical etiologies—including neurological disorders, structural changes, and postsurgical conditions—the QHP must integrate medical, behavioral, and functional considerations throughout the session.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to CPT code 92651 *Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report* (work RVU = 0.98 and 30 minutes intra-service time). This code is a valid comparator as it is valued similarly. The reference CPT code has similar intra-service and total times, suggesting that the surveyed code should be valued similarly.

For additional support, the RUC HCPAC referenced CPT code 97550 *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes* (work RVU = 1.00 and 30 minutes intra-service time). The surveyed code intra-service and the total time are slightly higher, albeit similar to the reference code, suggesting that they should be valued similarly. **The RUC HCPAC recommends a work RVU of 0.98 for CPT code 92X8X.**

**92X9X *Treatment of voice, upper airway dysfunction, and/or resonance disorders, direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary service)***
The RUC HCPAC reviewed the survey results from 58 speech-language pathologists and recommends a work RVU of 0.48 based on the survey 25$^{th}$ percentile, which maintains relativity within the family for this add-on service. The RUC HCPAC recommends 20 minutes of intra-service time.

When additional treatment time beyond the first 30 minutes is needed, the intensity of professional work does not simply increase linearly with time. Longer treatment durations reflect greater clinical demands, including managing patient fatigue, adapting strategies in real time, addressing more complex behavioral patterns, and sustaining a high level of therapeutic engagement. The QHP must continuously modulate techniques, monitor physiologic and behavioral cues, and recalibrate interventions to maintain treatment effectiveness. This escalation in cognitive load and decision-making justifies the 25$^{th}$ percentile work RVU for the add-on code.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service code 97130 *Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.48 and 15 minutes intra-service time). The surveyed code recommended work RVU is appropriately supported by the key reference service, given the lower intensity/complexity to perform the service, albeit the higher intra-service and total time.

For additional support, the RUC HCPAC referenced MPC code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45 and 15 minutes intra-service time). This code is a valid comparator as the intra-service and total time are slightly lower when compared to the surveyed code, suggesting that the surveyed code recommended work RVU is appropriately higher. Additionally, MPC code 97533 *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes* (work RVU = 0.48 and 15 minutes intra-service time) is a valid comparator, which has similar times to the surveyed code, and therefore, the surveyed code should be valued similarly to the MPC code. **The RUC HCPAC recommends a work RVU of 0.48 for CPT code 92X9X.**

**92508** ***Treatment of speech, language, voice, communication, and/or auditory processing disorder, group, 2 or more individuals***
The RUC HCPAC reviewed the survey results from 68 speech-language pathologists and recommends a work RVU of 0.28 based on the survey median of one patient in a group of three typical patients, which maintains relativity within the family for this code. The RUC HCPAC recommends 2 minutes of pre-service evaluation time, 15 minutes intra-service time, and 3 minutes post-service time. To determine the appropriate work RVU for this service, a custom survey question was added to assess the total time and work RVU for the group as a whole. Additionally, the survey asked respondents to indicate the average number of patients that are typically represented in a group treatment session. This custom survey methodology was reviewed and approved by the Research Subcommittee. The question yielded a median response of three patients. The survey median work RVU of 0.85 and service period times were divided and adjusted by the typical number of patients represented per session (i.e., three patients), which reflects the per-patient work RVU (0.85/3 patients = 0.28 work RVUs) and service period times (45/3 patients = 15 minutes).

Group therapy treatment requires a high level of clinical complexity, cognitive workload, and a high level of professional engagement. Group treatment often targets pragmatic communication and functional problem-solving, requiring the QHP to monitor individual behaviors, elicit participation, and adapt the session dynamically to ensure that each patient benefits from the group context. The QHP guides structured discussion and collaborative analysis of real-world communication challenges, prompting patients to interpret situations, articulate strategies, and respond to peer contributions. This demands continuous clinical judgment to balance participation, scaffold communication attempts, and manage varied cognitive and linguistic abilities within the same session. The QHP also provides individualized explanations, demonstrations, and instructions for tasks between sessions to support skill carryover across settings.

To support the recommended work RVU, the RUC HCPAC compared the surveyed code to the top key reference service code 97150 *Therapeutic procedure(s), group (2 or more individuals)* (work RVU = 0.29 and 10 minutes intra-service time). The surveyed code is valued appropriately lower than the key reference services, given that the intensity and complexity to perform the service is lower, albeit the higher intra-service and total time of the surveyed code. Both the surveyed code and this reference code are group codes that typically involve a median of 3 group members. The RUC also referenced MPC code 97032 *Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes* (work RVU = 0.25 and 15 minutes intra-service time). The MPC code and surveyed code have identical intra-service time and similar total time, suggesting that they should be valued similarly.

For additional supported, the RUC HCPAC referenced CPT code 97552 *Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers* (work RVU = 0.23 and 9 minute intra-service time). The reference code and surveyed code are similar as they are both group services and surveyed using the same custom methodology. One key difference is the reference code would typically involve treating a typical group of 5 patients and the surveyed code treating a typical number of 3 patients. The surveyed code is valued appropriately higher as the intra-service and total time are higher than the reference code, although the intensity complexity of the codes is similar. **The RUC HCPAC recommends a work RVU of 0.28 for CPT code 92508.**

**Practice Expense**
The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that there has been a change in the way the Speech-Language Pathology services are provided necessitating changes in the supplies and equipment used. The Subcommittee noted that the speech-language pathologist will provide 100% of the intra-service work and there is no clinical labor time included in the recommendations. The PE Subcommittee reviewed the direct practice expense inputs and made one modification to remove ED038 *notebook (Dell Latitute D600)* as CMS considers computers to be an indirect expense. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

**Work Neutrality**
The RUC recommendations for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

**C. Adaptive Behavior Services (97151, 97152, 97X1X, 97X2X, 97X3X, 97153, 97154, 97X4X, 97X5X, 97155, 97X6X, 97156, 97157, 97158)**
**Scott Sperling, PsyD (APA psychology)**

At the September 2025 CPT Editorial Meeting, six codes were created, and eight existing codes were revised to specify appropriate time, define terms, address reporting gaps, and clarify reporting for technician and physician/QHP face-to-face and non-face-to-face adaptive behavior services. Two existing Category III codes to report technician time, 0362T and 0373T, were deleted. The existing CPT codes 97151-97158 are currently contractor priced. CPT codes 97151-97158 have never been surveyed by the RUC HCPAC Review Board. The revised code family was reviewed at the January 2026 RUC HCPAC Review Board meeting.

**CPT Codes 97151, 97152, 97X1X, 97X2X, 97X3X, 97153, 97154, 97X4X, 97X5X, 97155, 97X6X, 97156, 97157, 97158**
The RUC HCPAC Review Board reviewed the recommendation from the specialty societies to contractor price all 14 of the adaptive behavior service codes. The existing codes 97151-97158 are currently contractor priced. The specialty societies noted that since these services are currently contractor priced and existing payment models and practice patterns are varied, the newly revised code family should remain contractor priced. The RUC HCPAC Review Board agreed with the recommendation of contractor pricing for all 14 codes. The HCPAC Review Board understands that when contractor priced services become widely performed, the RAW will request an action plan to survey and review the services.

**The RUC HCPAC Review Board recommends contractor pricing for CPT codes 97151, 97152, 97X1X, 97X2X, 97X3X, 97153, 97154, 97X4X, 97X5X, 97155, 97X6X, 97156, 97157, 97158.**

**D. Real-time Fluorescence Wound Imaging (976XX)**
**Carrie Kerby, MSN (ANA)**

At the September 2025 CPT Editorial Meeting, a new code was created to report real-time florescence wound imaging. The existing Category III CPT codes to report this service, 0598T and 0599T, were deleted. The new code was reviewed at the January 2026 RUC HCPAC Review Board meeting.

**976XX *Real-time fluorescence wound imaging with clinical darkness to identify presence, location, load of bacteria and measure wound size, per day***
The RUC HCPAC Review Board reviewed the recommendation from the specialty societies to contractor price the new CPT code 976XX for real-time fluorescence wound imaging. The specialty society reviewed utilization data related to this new code and determined it would be unable to conduct a successful survey. While the Medicare utilization is considered high for the two deleted Category III codes and is typically performed by nurse practitioners, the public NPI data from CMS demonstrated that there are too few nurse practitioners reporting this service to meet the minimum survey threshold using a targeted survey, and the service is not widely performed across the US, often limited to specific geographic locations. Additionally, the specialty society pointed out that the coding change application (CCA) did not list nurse practitioners as a specialty performing the service; otherwise, the specialty would have taken the opportunity to submit comments to the CPT Editorial Panel regarding the utilization patterns. Therefore, the RUC HCPAC Review Board agreed with the recommendation of contractor pricing.

**The RUC HCPAC Review Board recommends contractor pricing for CPT code 976XX.**

**Referral to the CPT Editorial Panel**
The HCPAC Review Board recommended to refer the letter submitted by the specialty society describing the current utilization of the new real-time fluorescence wound imaging CPT codes to the CPT Editorial Panel for consideration.

**Multi-Specialty Points of Comparison (MPC) List Updates**
The HCPAC Review Board reviewed the addition of CPT codes 90846, 90847, 96158, 96159, 96202, 96203, 97129, and 97130 to the HCPAC Multi-Specialty Points of Comparison (MPC) list. **After review, the HCPAC voted to accept the addition of CPT codes 90846, 90847, 96158, 96159, 97129, and 97130 to the HCPAC MPC list given that they met the majority of absolute and suggested criteria.**

**The RUC filed the HCPAC Review Board report.**

## XIII. Multi-Specialty Points of Comparison (MPC) Workgroup (Tab 28)

Doctor Margie Andreae, Chair, provided the Multi-Specialty Points of Comparison (MPC) Workgroup report to the RUC.

**Review of Services 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 26 codes based on the sunset review and add 8 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 32 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.

Of the 32 total services that were identified in the sunset review, 19 services did not receive any specialty society response to maintain, thus the Workgroup agreed to delete them off the MPC list.

In their discussion, the MPC Workgroup made the following decisions regarding the specialty society recommendations to maintain services on the MPC list:

- The American Academy of Dermatology Association and American College of Emergency Physicians recommended maintaining CPT codes 12001, 12002, 12004, 12011, and 12013. However, the MPC Workgroup disagreed and voted to not maintain them on the MPC list, noting that the code values were based on methodology other than the survey results and that removing the codes would not create a gap because several other codes in same range are on the MPC list.
- The American Academy of Dermatology Association, American Academy of Otolaryngology-Head and Neck Surgery, American College of Emergency Physicians, and American Society of Plastic Surgeons recommended maintaining CPT code 12052 on the MPC list, to which the MPC Workgroup agreed.
- The American College of Radiology recommended maintaining CPT codes 74178 and 74176. However, the MPC Workgroup disagreed and voted to not maintain them on the MPC list, noting that the code values were based on methodology other than the survey results and that removing the codes would not create a gap.
- The College of American Pathologists and American Academy of Dermatology Association recommended maintaining CPT codes 88304 and 88305 on the MPC list, to which the MPC Workgroup agreed.
- The American Optometric Association recommended maintaining CPT codes 92081 and 92082 on the MPC list, to which the MPC Workgroup agreed.
- The American Academy of Pediatrics recommended maintaining CPT code 99392 on the MPC list, to which the MPC Workgroup agreed.

**The MPC Workgroup recommends sunsetting the following 19 services off the MPC list, none of which received a request to maintain by the specialty societies: 51741, 93922, 93923, 51705, 11042, 95805, 10060, 51710, 99460, 52005, 95810, 11043, 52281, 52287, 11044, 52630, 15823, 57288, and 53440.**

**The MPC Workgroup recommends removing the following 7 services, noting but disagreeing with the specialty societies' requests to maintain: 12001, 12011, 12002, 12013, 12004, 74176, and 74178.**

**The MPC Workgroup agreed with the specialty society request to maintain and recommends maintaining the following 6 services on the MPC list: 88304, 92081, 92082, 88305, 99392, and 12052.**

**MPC List Services Additions**
The MPC Workgroup annually solicits specialty societies for services that should be added or deleted from the MPC list. There were 10 services submitted for addition to the MPC list.

Prior to the MPC Workgroup meeting, the American College of Cardiology, American College of Radiology, American College of Surgeons, Outpatient Endovascular and Interventional Society, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology, and Society for Vascular Surgery withdrew their recommendation to add CPT code 37288 to the MPC list.

In their discussion, the MPC Workgroup made the following decisions regarding the specialty society recommendations to add services on the MPC list:

- The American College of Surgeons, American Society of Colon and Rectal Surgeons, American Pediatric Surgical Association, American College of Obstetricians and Gynecologists, and American Urological Association recommended adding CPT codes 49186, 49187, and 49190 to the MPC list, to which the MPC Workgroup agreed.
- The American College of Obstetricians and Gynecologists recommended adding CPT code 58580 to the MPC list, to which the MPC Workgroup agreed.
- The American Association of Neurological Surgeons and Congress of Neurological Surgeons recommended adding CPT codes 61624 and 61626 to the MPC list, to which the MPC Workgroup agreed.
- The American Academy of Ophthalmology recommended adding CPT codes 67312 and 92133 to the MPC list, to which the MPC Workgroup agreed.
- The American College of Radiology and American Society of Neuroradiology recommended adding CPT code 70472 to the MPC list. However, the MPC Workgroup disagreed and voted to not add this service to the MPC list at this time and suggested the specialty societies consider bringing this request forward at a future date when more data is available on this new code.

**The MPC Workgroup recommends adding the following 8 services to the MPC list: 92133, 58580, 67312, 61626, 61624, 49186, 49187, and 49190.**

**The MPC Workgroup does not recommend adding the following service to the MPC list: 70472.**

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

## XIV. Relativity Assessment Workgroup (RAW) (Tab 29)

Doctor Amr Abouleish, Chair, provided the report of the Relativity Assessment Workgroup (RAW). Dr. Abouleish highlighted that there are requests for action plans for the April 2026 regarding 1) destruction of premalignant lesion codes that were identified on the recent OIG report for 010-day global periods in which post-operative visits may not be conducted and 2) qualified health care professionals (QHP) in which the QHP is inappropriately included in the clinical labor direct PE inputs since their work should be captured in the work RVU. For those issues, the action plan may specify the need to be surveyed for work and direct practice expenses reviewed; only direct practice expense reviewed; or the clinical staff type be adjusted.

Dr. Abouleish indicated that the following services were recommended to be surveyed for the April 2026 RUC meeting:

- Destruction of benign lesion (17110, 17111) – RUC reviewed over 20 years ago screen and 2025 OIG study on post-operative visits
- Closed treatment of distal radial fracture (25600, 25605) – different performing specialty from survey screen

- Endoscopic decompression of spinal cord (62380) – RUC do not use to validate physician work flag

Dr. Abouleish indicated to refer to the full Relativity Assessment Workgroup report for additional details. **The RUC approved the Relativity Assessment Workgroup (RAW) Report.**

## XV. Administrative Subcommittee (Tab 30)

Doctor John Proctor, Chair, provided the Administrative Subcommittee report.

*Review Rotating Seat Election Rules and Candidates Nominated (RUC Agenda Tab 31)*
The Subcommittee reviewed the nomination for the internal medicine rotating seat, Elizabeth Blanchard, MD from the American Society of Clinical Oncology (ASCO), and the nomination for the primary care rotating seat, Michael Perskin, MD from the American Geriatrics Society (AGS). The Subcommittee determined that Dr. Perskin met the primary care rotating seat qualifications.

The Administrative Subcommittee noted that "an election will be unnecessary when there is an unchallenged seat and the seat will be awarded to the candidate by voice vote," as is the case with both rotating seats this election.

*RUC Compelling Evidence Guidelines Revisions*
At the September 2025 RUC meeting, under new business, a RUC member requested that the Administrative Subcommittee review the Compelling Evidence Guidelines to consider additional itemization and/or organization of language to clarify Compelling Evidence definitions. Further, the RUC member requested that the Subcommittee review the compelling evidence standard of flawed methodology.

In January 2026, the Administrative Subcommittee reviewed compelling evidence revisions drafted by AMA staff and the Administrative Subcommittee chair. The RUC assumes that current published work relative values are correct unless compelling evidence is presented. A member asked to clarify the source code of "CMS/Other." Staff explained that the valuation source in the RUC database *CMS/Other* reflect services that were reviewed without explanation within rulemaking. The rationale for these work RVUs is unknown and, therefore, the RUC specifically states that codes with this source are based on a flawed methodology. It was further clarified that Harvard valued services are presumed to be correct unless a compelling evidence argument prevails.

The Subcommittee added clarifying language to "flawed crosswalk assumptions" by adding the parenthetical "(i.e., not meeting the RUC crosswalk criteria)" and referencing the RUC crosswalk guidelines and criteria located in the *Instructions for Developing Work RVU Recommendations* document on page 18.

**The Administrative Subcommittee recommends the following revisions to the RUC compelling evidence standards:**

**Compelling Evidence**

The following guidelines may be used to develop a "compelling argument" that the published relative value for a service is inappropriately valued:

1. Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

    a. technique

b. knowledge/technology
c. patient population
d. site-of-service
e. length of hospital stay
f. physician time

2. An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.

3. Evidence that technology has changed physician work (i.e., diffusion of technology).

4. Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

5. Evidence that incorrect assumptions were made in the previous valuation of the service by either the RUC or CMS, as documented, such as:

   a. a misleading vignette, survey and/or flawed crosswalk assumptions (i.e., not meeting the RUC crosswalk criteria[1]) in a previous ~~e~~valuation;

   ~~b. a flawed mechanism or methodology used int eh previous valuation by either the RUC or CMS, for example, evidence that no pediatricians were consulted in assigning pediatric values or CMS/Other source codes; and/or~~

   b. a source of valuation of "CMS/Other" (i.e., based on unknown methodology)

   c. valued using an unapproved methodology (e.g., flawed building block)

   d. the current published valuation excluded a specialty that currently provides a plurality of the service.

[1] The RUC crosswalk criteria are located in the Instructions for Developing Work RVU Recommendations document, page 18

*RUC Confidentiality Agreement*

At the September 2025 RUC meeting, under new business, a RUC member requested review and consider modifications to the RUC's Confidentiality Agreement to be consistent with the recent revisions by the CPT Editorial Panel to the CPT Confidentiality Agreement.

The AMA Office of General Counsel (OGC) reviewed the current RUC Confidentiality Agreement and proposed edits to promote transparency and mirror changes in the CPT Confidentiality Agreement where applicable. The key changes in the confidentiality agreement are to elaborate on permitted activities, such as comments made in RUC meetings being removed from the veil of confidentiality as long as they are not attributed to an individual. The new agreement provides that the RUC recommendations, once submitted to CMS and published on the AMA website, are not subject to confidentiality restrictions. The RUC recommendations will now be posted approximately one month following each RUC meeting rather than following the CMS Proposed Rule release each year.

The Administrative Subcommittee reviewed the revisions proposed to the RUC Confidentiality Agreement by the AMA OGC and recommended accepting without edits. **The RUC accepted the revised Confidentiality Agreement by 2/3 vote. The revised Confidentiality Agreement is attached to these minutes.**

**The RUC approved the Administrative Subcommittee Report.**

*RUC Rules and Procedures*
Due to the revisions to the RUC Confidentiality Agreement, section *V. Confidentiality and Proprietary Rights,* of the RUC *Rules and Procedures* document needed updating. The AMA Office of General Counsel (OGC) provided edits to this section. Via e-mail on February 12, 2026, the Administrative Subcommittee reviewed and approved the following edits:

**V. Confidentiality and Proprietary Rights**

A. All representatives of the RUC, observers and participants in the Process acknowledge by their participation that any information or materials provided by the AMA or the RUC must be handled in accordance with the terms of the RUC confidentiality agreement then in effect. ~~is confidential and/or proprietary and shall be kept confidential and shall only be used and disseminated for internal use within their organization as provided for by the Process. All representatives to the RUC, observers and participants in the Process acknowledge that all RUC deliberations are confidential and shall not be disseminated or discussed with individuals outside of the RUC Process.~~ The AMA ~~, specialty societies or HCPAC organizations~~ may disseminate information and data developed during the Process in accordance with the terms of the RUC confidentiality agreement then in effect ~~with prior written approval by the majority of the RUC. The RUC will consider such requests only after the publication by the Centers for Medicare and Medicaid Services of interim or final relative values for codes considered under the RUC process~~. The RUC ~~will~~ may disseminate vote totals for each CPT code (ranging from 29-0 to 20-9) to the public in accordance with the terms of the RUC confidentiality agreement then in effect ~~upon release of the Final Rule for each Medicare Physician Payment Schedule. Any other distribution of materials is strictly prohibited~~.

**The RUC approved the changes to the RUC Rules and Procedures via e-mail on February 13, 2026.**

## XVI. Rotating Seat Election (Tab 31)

The rotating seat elections occurred on Saturday, January 17, 2026.

Elizabeth Blanchard, MD from the American Society of Clinical Oncology (ASCO) was elected to the RUC's internal medicine rotating seat and Michael Perskin, MD from the American Geriatrics Society (AGS) was elected to the primary care rotating seat.

The term for these rotating seats is two years, beginning in March 2026 and ending in February 2028 with the provision of final recommendations to CMS.

## XVII. New/Other Business (Tab 32)

- A RUC member inquired about the EHR time-based project and if the work will include review of AI scribes and their time relationship with commonly performed services, such as E/M Office Visits. Staff clarified that the pilot study with the University of Maryland and University of California San Francisco is focusing on learning if RUC time standards (eg, clinical staff time and procedure report time) can be validated with EHR audit log data.

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

- A RUC member inquired about the process for assigning global periods. It was explained that specialties indicate information within the CPT coding application and work with AMA RUC staff to estimate global period assignments. These draft assignments are shared with CMS. Another member mentioned that the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) prohibited elimination of the 010-day and 090-day global periods and instead called for data collection efforts on the accuracy of post-service work, which have resulted in the recent RAND and OIG reports, reviewed by the RAW at this meeting.

- A RUC member suggested that AMA staff review codes that have been valued by the RUC in this cycle to determine if the intra-service times have decreased or not. For codes that did not decrease in intra-service time, the member suggested that the RUC should submit to CMS that efficiency had not been achieved. AMA staff responded that new evidence related to the efficiency adjustment must be submitted to CMS by February 10, 2026, and the RUC will provide this new evidence in its cover letter to CMS by this date.

- A RUC member suggested that the recommended guidelines and criteria for crosswalks be reviewed by the Research Subcommittee to review the criteria related to the clinical similarity between the surveyed and crosswalk code.

- A RUC member noted the proposed changes to the medical decision making (MDM) table for discussion at the February 2026 CPT Editorial Panel meeting. The RUC member asked if these issues would be referred to the former joint CPT and RUC E/M workgroup. Staff Note: The CPT Editorial Panel has disbanded this workgroup, and all discussion on the coding proposal will be considered by the full CPT Editorial Panel.

The RUC adjourned at 3:08 PM PT on Saturday, January 17, 2026.