AMA/Specialty Society RVS Update Committee
The Westin Washington DC Downtown, Washington, DC
September 26-28, 2024

Meeting Minutes

I. Welcome and Call to Order

The RUC met in person in September 2024. Doctor Ezequiel Silva, III, called the meeting to order on Friday, September 27, 2024, at 8:02 a.m. ET. The following RUC Members and RUC Alternates were in attendance:

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

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

II. Chair's Report

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

- Doctor Silva 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. 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 attendee
  - Lawrence Simon, MD – CPT Panel Member

- Doctor Silva welcomed the Centers for Medicare & Medicaid Services (CMS) attendees:
  - Michael Aderinkola, B.Sc – CMS Fellow
  - Perry Alexion, MD – Medical Officer
  - Lindsey Baldwin – Director, Division of Practitioner Services
  - Thomas Levu, JD, MHSA – CMS Fellow
  - Michael Soracoe, PhD – Technical Advisor
  - Gift Tee – Deputy Director, Hospital and Ambulatory Policy Group (HAPG)

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

- Doctor Silva recognized a new Alternate RUC member:
  - Thomas Turk, MD (AUA)

- Doctor Silva recognized a dedicated, departing RUC participant:
  - Scott Collins, MD (AADA)

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

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

- Doctor Silva 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).
  - There is only one link for all votes!
  - You will need to have access to a computer or smartphone to submit your vote.
  - If you are unable to vote during the meeting, please notify AMA staff.
  - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports.

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

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

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

- Doctor Silva communicated the content of the Meeting with CMS attended earlier this month:
  - CPT and RUC Leadership met with CMS staff on Sept 9, 2024
  - RUC issues discussed:
    - High-Cost Disposable Supplies
    - Telemedicine E/M Services
    - Update on Physician Practice Information (PPI) Survey

III. Director's Report

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

- Ms. Smith conveyed the following information regarding the Physician Practice Information (PPI) Survey Update:
  - The PPI Survey has officially closed.
  - PPI Survey: 302 practice completes, additional 317 practice partial completes. Numerous multi-specialty and large health system completes.
  - Other Health Care Professional Small Practice Survey: 177 practice completes, additional 293 practice partial completes. Additional responses from multi-specialty practices, including large health systems will be added to these completes.
  - Next Steps:
    - Mathematica, working with AMA economists, will create the weighting methodology.
    - AMA economists will analyze data to compute Medicare Economic Index (MEI) weights and Practice Expense per Hour for "all physicians" and for numerous specialties and specialty groupings.
    - Summary data will be shared with specialty societies, the Centers for Medicare & Medicaid Services, and the survey respondents.
    - CMS must receive information by February 10, 2025, for consideration in rulemaking for the 2026 Medicare Physician Payment Schedule.

- Ms. Smith reviewed the RUC Database application:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets.
  - Download the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - The database reflects 2022 Medicare claims data and updated 2024 Conversion Factor (CF).

- Ms. Smith announced that RUC staff have developed 12 webinars to assist all participants in the RUC process:
  - The RUC Process webinars may be accessed via the RUC Collaboration home page or by clicking "General Resources" from the left navigation bar and then "New to the RUC" and "RUC Process Webinars & Presentations."
  - The RUC Process webinars may also be accessed directly via the YouTube link: https://www.youtube.com/playlist?list=PLpUAhDflHfcoS89T0wxivYpHmsYl8fxZp

- Ms. Smith announced the upcoming RUC Recommendation due dates and RUC meetings for the CPT 2026 and 2027 Cycle:

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Dec 10, 2024	Jan 15-18, 2025	Anaheim, CA	CPT 2026
Apr 1, 2025	Apr 23-26, 2025	Chicago, IL	CPT 2027
Aug 26, 2025	Sep 25-27, 2025	Chicago, IL	CPT 2027

- Ms. Smith announced that the RUC now offers Continuing Medical Education (CME) credits for RUC Meeting Participation:
  - Physicians can earn up to 25.00 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 October 4, 2024.
  - Once you've successfully completed the evaluation, a certificate will be automatically available on October 18, 2024, in the "Transcript" section of your AMA Ed Hub account.

IV. Approval of Minutes from the April 2024 RUC Meeting

The RUC approved the April 2024 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 recent September 2024 CPT meeting, where 82 items of business were discussed.

- Notable Agenda Items
    - 7 Digital medicine related Coding Change Applications (CCAs), 25 Category III code applications, and 3 RUC referrals to CPT
    - Transition Care Services Guidelines (Tab 5): Request to revise guidelines to remove reference to "inpatient" to allow reporting for the emergency room. WITHDRAWN.
    - Category III to Category I - Percutaneous Interlaminar Lumbar Decompression (Tab 7): Establish two codes for reporting percutaneous interlaminar lumbar decompression; and delete code 0275T
    - Category III to Category I-Irreversible Electroporation of Tumors (Tab 10): Establish a code for reporting percutaneous multiprobe irreversible electroporation ablation; and delete a Category III code.
    - Category III to Category I-Cystourethroscopy (Tab 11): Establish a code to report cystourethroscopy; and delete a Category III code.
    - Category III to Category I-Percutaneous Electrical Nerve Field Stimulation (Tab 12): Establish a code to report percutaneous electrical nerve field stimulation of cranial nerves; and delete a Category III code.
    - Category III to Category I-Baroreflex Activation Therapy Services (Tab 13): Establish six codes for reporting baroreflex activation therapy (BAT) modulation system procedures; establish two codes for reporting interrogation device evaluation programming services; and delete eight Category III carotid sinus baroreflex activation therapy services codes.
    - Endoscopic Sleeve Gastroplasty (ESG) (Tab 19): Establish a code to report gastric restrictive procedures through an endosurgical approach
    - Laminotomy-Repair of Disk Defect w Annular Closure Device (ACD) (Tab 27): Establish a code to report laminotomy (hemilaminectomy) with decompression using an annular closure
    - Lower Extremity Vascular Procedures (Tab 30): Establish 46 codes for reporting vascular procedures in the iliac vascular territory; vascular procedures in the femoral and popliteal vascular territory; vascular procedures in the inframalleolar vascular territory; delete 16 lower extremity revascularization codes.
    - Hip and Pelvis Arthrodesis Guideline Revisions (Tab 25): Revise guidelines and descriptors for two codes to clarify intended use for both codes
    - Sacroiliac Joint Arthrodesis(Tab 34): Revise a code to provide additional instruction for intent of reporting
    - Sacroiliac Joint Fusion - Revise 27279 Guideline (Tab 37): Revise guidelines for code 27279 to clarify intended use
    - Percutaneous Release of Transverse Carpal Ligament (Tab 33): Establish a code to report decompression of the median nerve at the carpal tunnel percutaneously
    - Thoracic Branch Endograft Services (Tab 36): Establish two codes to report for thoracic branch endograft services; revise four codes; and delete seven codes
    - Category III to Category I-Coronary Atherosclerotic Plaque Assessment (Tab 39): Establish a code for reporting quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease; and delete four Category III codes

  - Radiation Oncology Treatment Delivery (Tab 40): Referred by the RUC to CPT. Deletion of three codes; add and revise guidelines; and revise three codes to consolidate services radiation treatment delivery
  - Superficial Radiation Therapy (Tab 41): Establish five codes to report surface radiation therapy; and delete one code
  - Biofeedback Training (Tab 49): Referred by the RUC to CPT. Establish and add-on code for biofeedback training; and revise a code
  - Category III to Category I-Scalp Cooling Services (Tab 53): Establish three codes to report scalp cooling services; and delete two codes
  - Combination COVID-19 Vaccine Administration (Tab 55): Revise a code to note first or only component; and establish a code to report each additional non-COVID vaccine component administration.
  - Hyperbaric Oxygen Practice Expense (Tab 57): Referred by the RUC to CPT. Request to add a code to report hyperbaric oxygen under pressure therapy – WITHDRAWN
  - Modifier 25 and 57 Revisions (Tab 84): Request to revise Modifier 25 and Modifier 57.
  - Remote Monitoring (Tab 85): Revise the Digitally Stored Data Services/Remote Physiologic Monitoring guidelines; add a remote physiologic monitoring device supply code for 2 to 15 calendar days; revise a code 99454; revise the Remote Physiologic Monitoring Treatment Management services guidelines; add a new code for remote physiologic monitoring treatment management services to include 10 minutes of service; revise two codes; revise the Remote Therapeutic Monitoring Services guidelines; revise four codes; add three remote treatment monitoring device supply codes to report respiratory, musculoskeletal and cognitive behavioral therapy for 2-15 calendar days; revise the Remote Therapeutic Monitoring Treatment Management services guidelines; add a new Remote therapeutic monitoring treatment management services code to include 10 minutes of service; revise two codes.

- CPT Ad Hoc Workgroups: Update - Maternity Care Services Workgroup
  - Co-Chairs: Padma Gulur, MD and Timothy L. Swan, MD
  - Workgroup Charge: The Workgroup will assess the current practice of Maternity Care including antepartum care, labor management, delivery, and postpartum services to bring forth a Code Change Application with suggested changes to existing codes as well as proposed new codes which reflect the current practice of medicine while aligning to the rules, guidelines, and conventions of the current CPT code set, while meeting the needs of all stakeholders.

- Upcoming CPT Editorial Panel Meetings
  - The next Panel meeting is February 6-8, 2025 – San Jose, California
  - The next application submission deadline is November 1, 2024, for the February 2025 CPT Editorial Panel meeting.

- Doctor Simon addressed questions from attendees:
  - A RUC member inquired about specialty society pressure related to growth in code change applications (CCAs) that come to the CPT Editorial Panel. Doctor Simon responded that the CPT application process is open to the general public and acknowledged the increase in CCAs submitted by industry and individual physicians. Doctor Simon continued that as a stakeholder, it is important to support innovation and technology. It was noted that all Category I new codes originating from the September 2024 Panel meeting had at least one specialty society support the application. The RUC chair added that the RUC will continue to evaluate proposals from CPT, no matter the

originating body, as effectively as possible, and make credible recommendations using the expertise of RUC members and participants.

- A RUC member inquired about the E/M workgroup and upcoming issues that may need RUC involvement. Doctor Simon responded that the E/M Workgroup is a joint RUC / CPT workgroup and therefore the RUC would be involved in future deliberations of the workgroup.

VI. Centers for Medicare & Medicaid Services Update

Lindsay Baldwin, Director, Division of Practitioner Services, provided the report of the Centers for Medicare & Medicaid Services (CMS) with highlights of the CY 2025 Medicare Physician Payment Schedule (MFS) Proposed Rule.

- CMS 2025 Proposed Rule
  - On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announced and solicited public comments on proposed policy changes for Medicare payments under the Medicare Physician Payment Schedule (MFS), and other Medicare Part B issues, on or after January 1, 2025. The calendar year (CY) 2025 MFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation for all Medicare beneficiaries.
  - The 60-day comment period closed on September 9, 2024, and CMS is actively working on reviewing the comments received. We thank the AMA and other interested parties for their comments.
  - Some of the topics covered in the proposed rule include:
    - CY 2025 MFS Rate-Setting/Conversion Factor
    - Telehealth Services under the MFS
    - Office/Outpatient (O/O) Evaluation and Management (E/M) Visits
    - Cardiovascular Risk Assessment and Management
    - Strategies for Improving Global Surgery Payment Accuracy
    - Caregiver Training Services
    - Dental and Oral Health Services
    - Caregiver Training Services (CTS)
    - Services Addressing Health-Related Social Needs (Community Health Integration (CHI), Social Determinants of Health (SDOH), and Principal Illness Navigation (PIN) Services)
    - Behavioral Health Services
    - Note: The Proposed Rule includes proposed changes not reviewed in this presentation, please refer to the proposed rule for complete information

VII. Contractor Medical Director Update

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

- Newly Effective Local Coverage Determinations (LCDs)
  - The following LCDs became effective on August 1, 2024: Caregiver Training
    - Cervical Fusion
    - Molecular Pathology Procedures (Ceramides testing, 0119U, to risk stratify patients at risk for atherosclerotic events, determined to be not covered)

  - Facet LCD (revision for clarification regarding Radiofrequency Ablation **(**RFA) and Monitored Anesthesia Care).
  - KidneyIntelX (Testing to identify and stratify patients with Type 2 diabetes **(**T2D) and early-stage chronic kidney disease **(**CKD) into low, intermediate, and high risk for near-term rapid progressive decline in kidney function. Early identification of high-risk patients allows for more intensive patient management, selection of appropriate medications, and appropriate specialty referral or consultation.)

- Scheduled Contractor Advisory Committee **(**CAC) and LCDs Under Consideration
  - CAC
    - Evidentiary CAC scheduled for Superficial Radiation Therapy for Nonmelanoma Skin Cancers on Oct 17th 2024
  - LCDs
    - Botulinum Toxin Injections (LCD comment period has ended and comments are now under consideration).
    - Waterjet Prostate Ablation (Reconsideration Requests being reviewed by multiple Medicare Administrative Contractors (MACs), "a little "c" collaboration")

- Molecular Genomics
  - Molecular Genomics now includes Proteomics
  - Proteomics is a new type of 'omics' that has rapidly developed, especially in the therapeutics field. The word proteome was created by Marc Wilkins in 1995.
  - Proteomics is the study of the interactions, function, composition, and structures of proteins and their cellular activities
  - Proteomics provides a different level of understanding of the structure and function of the organism than genomics.
  - Protein expression can be altered according to time and environmental conditions.
  - Proteomics tests as defined above must be billed with an appropriate CPT code. These may be found in the Multianalyte CPT code set or may utilize the Not Otherwise Classified (NOC) code 81599; or may be defined by a relevant Proprietary Laboratory Analyses **(**PLA) code.
  - Given the complexity of these tests and the ambiguity of services rendered, all proteomics tests in MolDX jurisdictions must register with the DEX® Diagnostics Exchange Registry and obtain a Z-Code® identifier. (proprietary to MOLDx)
  - Clinical Utility (CU) (Same questions we constantly ask with Molecular Genomics)
    - How clinically useful is this test? Can it change management to improve patient outcomes?
    - The SO-WHAT? Factor
    - These are the questions to be answered by the LCD that is developed
    - New LCDs defining the use of molecular studies are being written all the time as the technology is rapidly evolving
    - Remember Not All MACs are part of the MOLDX collaboration so LCDs and determinations may vary
  - Dental
    - Still able to bill both CPT and Current Dental Terminology (CDT) codes
    - CMS in the process of upgrading their claims system to be able to accept electronic dental claim form that recognizes traditional CDT code billing
    - Still seeing a number of beneficiary submitted claims

        - Continuing to encourage dental providers to enroll into Medicare
        - Still working with the American Dental Association (ADA) and through contractor provider outreach and education to get providers educated as to the requirements of participating and billing Medicare
    - Artificial Intelligence
        - Nothing new to report from the workgroup.
        - They are still evaluating the data in each jurisdiction as to its use
    - Telemedicine
        - No Updates

- Doctor Lawrence addressed questions from attendees:
    - A RUC member inquired about the cervical fusion local coverage determination (LCD) and related denials on lumbar fusions based on the cervical fusion LCD. The member pointed out that one code considered in the LCD is 22614 which is also applicable to lumbar fusion and thoracic fusion. It would be appreciated if Medicare Administrative Contractors (MACs) could look into why that code is included. Doctor Lawrence mentioned that they would look into this inquiry.
    - A RUC member inquired about the growth of pharmacogenomics and the role of both CPT and RUC going forward with this expanding field. Doctor Lawrence responded that the clear description of services by CPT helps to better inform CMDs definition of coverage. Further, the RUC recommendation for the proposals that come out of CPT also help inform the process.

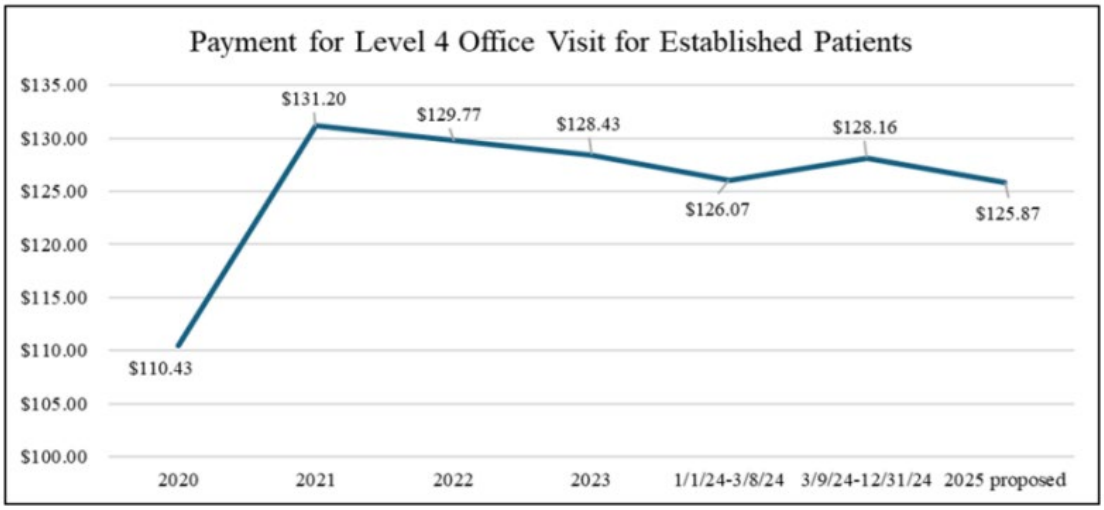
VIII. Washington Update

Jennifer Hananoki, JD, Assistant Director, Federal Affairs, AMA, and Chris Sherin, Assistant Director, Division of Congressional Affairs, AMA, provided the Washington report focusing on AMA Advocacy on Medicare Physician Payment Reform, Telehealth, MedPAC June Report to Congress, and a Congressional Update.

- AMA Comments: 2025 Medicare Physician Payment Schedule (MFS) and Quality Payment Program (QPP) Proposed Rule

- Reduction to Medicare Conversion Factor (CF)
    - The proposed rule predicts a 2.8 percent reduction in the 2024 Medicare CF, lowering it from $33.2875 to $32.3562. The anesthesia conversion factor is proposed to be reduced from $20.7739 to $20.3340.
    - This cut is largely the result of the expiration of a 2.93 percent temporary update to the CF at the end of 2024 and a zero percent baseline update for 2025 under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA).
    - These cuts coincide with ongoing growth in the cost to practice medicine as CMS projects the increase in the Medicare Economic Index (MEI) for 2025 will be 3.6 percent.

- Five Years of Payment Cuts



- Quotes related to the Impact of Payment Cuts on Physicians and Patients
    - "Emergency rooms are seeing this crisis in a very specific and targeted way," said an emergency medicine physician from Ohio. "What we're seeing is more patients coming to the emergency department because they can't access care [for (sic)] their primary doctor or their specialist physicians, who either can [no] longer cover Medicare patients because of decreasing reimbursement or have reduced hours or services because of Medicare reimbursement… we're not necessarily the best place to provide ongoing primary care or to make medication adjustments or things that really patients should be seeing their primary or specialist physician for."
    - "Since many of the insurance products that we take in our office are indexed off of Medicare, every time Medicare cuts payment, since they're indexed off of Medicare, their payment is cut as well," said a family medicine physician in Virginia. "So it's not like Medicare will cut their payment and everybody else will stay the same and we'll be able to balance it. When Medicare goes down, everything goes down."
    - A general surgeon from Oregon told the AMA that "[a]s a private practice surgeon, I'm a small business owner, so ongoing Medicare cuts have forced me to spend less time with the patients… whom I want to take care."

- AMA to CMS: Be Transparent about Impact of Medicare Cuts
    - AMA called on CMS to be fully transparent with the public about the impact of these payment cuts by including the expiration of temporary statutory increases to the conversion factor in the specialty impact table. If those cuts affect the conversion factor, they will also affect specialists' payment rates.
    - We urged the Biden-Harris Administration to work with Congress to enact a permanent, annual inflation-based update to Medicare physician payments.
    - AMA comment letter

- Importance of Collaboration Between CMS and the CPT Editorial Panel to Achieve Shared Goals

  - There was a significant uptick in the number of G-codes in this proposed rule, which creates administrative burden for physicians and qualified health care professionals (QHPs) who report medical services to both Medicare and other payers.
  - In some instances, these proposed codes duplicate existing CPT codes (e.g., tympanostomy and caregiver training), potentially leading to confusion and increased administrative burden.
  - AMA strongly encouraged CMS to continue collaborating with the CPT Editorial Panel through their transparent review process.

- Practice Expense RVUs
  - The AMA supported CMS' decision to defer implementation of MEI changes to the distribution of RVU components within the RBRVS. The AMA agreed that CMS should allow for the review of data from the PPI Survey before implementing re-weighting that would result in significant redistribution within physician payment.
  - The AMA strongly supported the long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. High-cost supply prices should be annually reviewed and updated.
    - There are several CMS proposals (e.g., smart pillow) that support our recommendation.
  - The AMA agreed that it would be practical to update clinical staff, medical supply and medical equipment pricing consistently, for example, every five years. Updates to clinical staff prices and medical supply and equipment prices should occur simultaneously to reduce the redistribution effects of these updates across medicine.

- Telehealth: New CPT Codes
  - 2025 CPT changes include 4 code sets for E/M furnished via synchronous audio/video or audio-only telecommunications:
    - 98000-98003 – audio/video E/M for new patients
    - 98004-98007 – audio/video E/M for established patients
    - 98008-98011 – audio-only E/M services for new patients
    - 98012-98015 – audio-only E/M services for established patients
    - Also 98016 for virtual check-in
  - Except for 98016, CMS proposed assigning status indicator "I" which means another more specific code should be reported.
  - CMS says the Medicare statute does not allow Medicare to pay for these codes and that, instead, physicians should report in-person office visit codes with a telehealth modifier.

- AMA Comments on New CPT Codes
  - CMS is not reading the statute correctly. The new telehealth E/M codes are for services that can only be reported when a telecommunications system is used. They differ from in-person office visits and involve different resource costs. The RUC has made recommendations to CMS that are specific to these new telecommunications services; they would no longer be paid as if they were provided in-person.
  - Like remote monitoring, the new codes are not subject to telehealth section of the Medicare statute.
  - If the new codes are not subject to section 1834m, then they can be paid at different rates than for in-person visits. CMS was already paying different rates for telehealth visits than in-person visits before COVID – they were paying the facility rate instead of the nonfacility rate and previously proposed returning to that policy.

  - If Congress does not extend the current telehealth waivers, then these services will only be available to patients in rural areas, and only if they go to a medical facility to receive the services from a distant site. CMS adoption of new CPT codes for E/M telecommunications would avoid these restrictions if Congress fails to act.

- More Telehealth Comments
  - For 2025, CMS proposes a permanent change in the definition of an interactive telecommunications system to include audio-only services and AMA comments strongly support this change.
  - Since the Public Health Emergency (PHE), CMS has allowed physicians to be "immediately available" for services that require direct supervision through real-time interactive audio-video communications. The 2025 proposal would extend the policy on virtual direct supervision for one more year while making it permanent for a certain subset of services. AMA supports the extension but is recommending it be permanent for all services requiring direct supervision.
  - The AMA supports CMS' proposal to provide a one-year extension of its current policy allowing teaching physicians to provide virtual supervision of residents when the resident is delivering a service using telecommunications technology. In other words, the teaching physician, resident physician, and patient would be in 3 different locations. The AMA is also recommending that CMS establish a permanent policy allowing virtual supervision of residents for both remote and in-person services.
  - During the COVID PHE, CMS lifted frequency limits on subsequent visits that can be provided via telehealth to nursing facility patients and hospital inpatients and AMA has been urging the agency to lift these limits permanently. CMS proposes a one-year extension.
  - The AMA supports CMS' proposal to continue its current policy of not requiring physicians to report their home address through the end of 2025 and to use their currently enrolled practice location when providing telehealth services from their home.

- Expanded Transfer of Care Modifiers
  - CMS proposed to require the use of the appropriate transfer of care modifier (modifier -54, -55, or -56) for all 90-day global surgical packages in any case when a practitioner plans to furnish only a portion of a global package, both when there is a formal, documented transfer of care (current policy) and when there is an informal, non-documented but expected, transfer of care.
  - AMA commented that the accompanying payment reduction should not apply to any services that have the multiple procedure reduction modifier -51, informed consent should be required, and CMS should provide extensive education and outreach.
  - AMA again called on CMS to incorporate the full increases for the inpatient hospital and observation care visits and office visits into the 10-day and 90-day surgical global periods.

- Medicare Shared Savings Program (MPPS) Accountable Care Organizations (ACOs)
  - AMA comments on 2025 proposals:
    - Reiterated that CMS should not require all MSSP ACO participants, including qualified participant (QPs), to report Merit-based Incentive Payment System (MIPS) promoting interoperability (PI) measures as Medicare Access and CHIP Reauthorization Act (MACRA) exempts QPs and partial QPs from MIPS
    - Supported holding ACOs harmless from anomalous spending, such as $2 billion in suspect catheter billing in 2023

        - Urged CMS to reconsider sunsetting Web Interface reporting option
    - AMA, American College of Physicians (ACP), and American Academy of Family Physicians (AAFP) hosted a webinar with Capability Maturity Model Integration (CMMI) staff on new ACO Primary Care (PC) Flex model and released FAQs
    - ACO PC Flex begins in 2025 and ACOs will receive an upfront shared savings payment of $250,000 and monthly prospective payments for primary care services

- Merit-based Incentive Payment System (MIPS)
    - AMA supported CMS' proposal to maintain the performance threshold at 75 points
    - We opposed making MIPS Value Pathways (MVPs) mandatory and requiring multi-specialty groups to form subgroups to report MVPs. The AMA continued to call on CMS to improve MVPs by focusing on conditions and episodes
    - The AMA supported CMS' proposal to remove a 7- point cap on certain topped-out measures but urged CMS to expand the policy to ALL topped-out measures
    - We urged CMS to remove the Total Per Capita Cost measure and apply its cost measure scoring changes beginning in PY 2023

	Estimated median final score	Estimated percent receiving a penalty
All MIPS ECs	86.42	15%
All solo practitioners	75.00	46%
All small practices	86.02	21%
All rural practitioners	85.41	16%
Rural solo practitioners	75.00	46%
Rural small practices	87.34	20%
All safety net practitioners	88.59	14%
Safety net solo practitioners	65.78	52%
Safety net small practices	84.50	27%

- 2023 MIPS Scores Finalized
    - On August 12, CMS published final 2023 MIPS scores and corresponding 2025 bonuses and penalties
    - Reminder: there is no exceptional performance bonus for the 2023 performance period
    - Deadline to file an appeal ("targeted review") is Oct. 11, 2024, at 8 pm ET
        - Reasons include:
            - Data were submitted under the wrong TIN or National Provider Identifier (NPI).
            - You have Qualifying APM Participant (QP) status and shouldn't receive a MIPS payment adjustment.
            - Performance categories weren't automatically reweighted even though you qualify for reweighting due to extreme and uncontrollable circumstances.
    - For more information: www.qpp.cms.gov

- MedPAC June 2024 Report to Congress

- Chapter 1: Approaches for updating clinician payments and incentivizing participation in Alternative Payment Model (APMs)
    - MedPAC acknowledges concern about payment adequacy in the future due to gap between physician input costs and Medicare payment rates

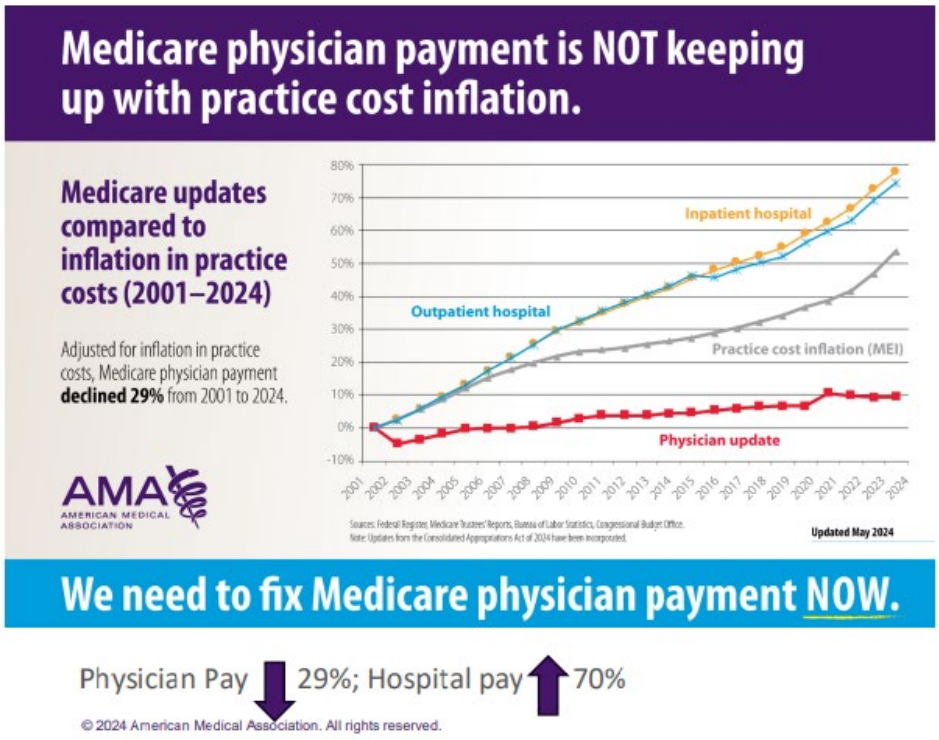
  - "This larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat or stop participating in Medicare entirely."
  - AMA letter commending MedPAC and offering comments on proposed approaches

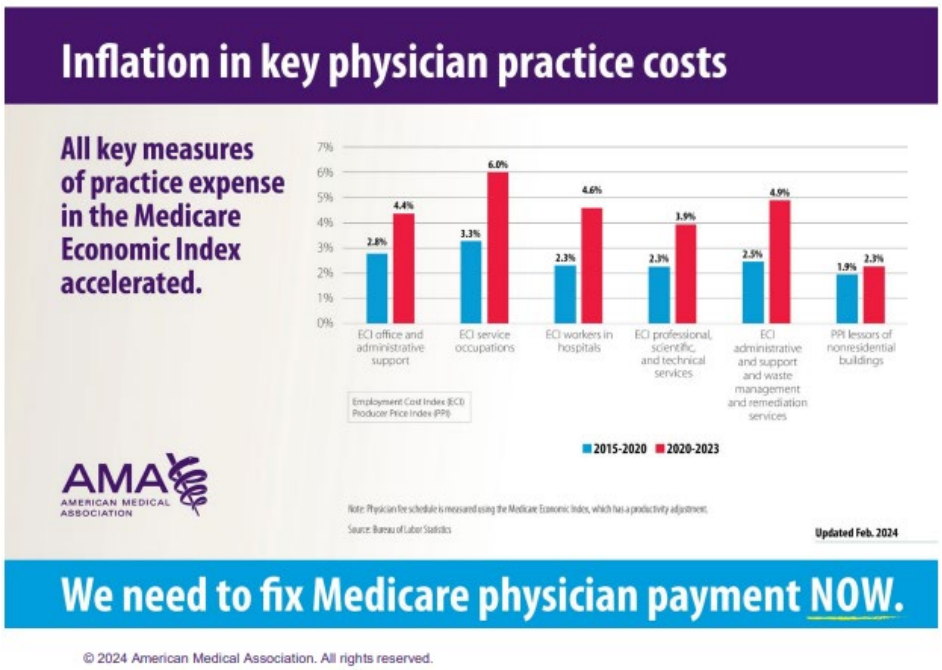
- MedPAC June 2024 Report to Congress

- Medicare Physician Payment System Presents Short-term and Long-term Challenges
  - The American Medical Association (AMA) is working on a multitude of legislative priorities, however, this presentation will cover Congressional activity in the 118th Congress pertaining to short-term and long-term Medicare payment reform priorities, extension of telehealth flexibilities, and simplifying/streamlining prior authorization within Medicare Advantage.
  - All three of these broad policy priorities are key pillars of AMA's Recovery Plan for America's Physicians.
  - More specifically, the presentation will address:
    - AMA's Medicare physician payment reform legislative platform.
    - Trends affecting Medicare physician payment from 2001-2024.
    - H.R. 2474, the Strengthening Medicare for Patients and Providers Act.
    - House Dear Colleague Letter in Opposition to the latest 2.8% cut to the Medicare Physician Fee Schedule Conversion Factor.
    - Budget Neutrality Reform: H.R. 6371, the Provider Reimbursement Stability Act.
    - Draft Legislation to overhaul key portions of the Merit-based Payment Incentive System (MIPS).
    - House bills that temporarily extend COVID-19 Medicare telehealth flexibilities.
    - H.R. 8702/S. 4532, the Improving Seniors' Timely Access to Care Act.

- AMA Medicare Payment Reform Platform
  - AMA's Medicare payment reform legislative platform consists of four main components:
    - Provide physicians with a permanent, inflationary update equivalent to the MEI.
    - Enact targeted reforms to the MFS budget neutrality requirements.
    - Overhaul the MIPS formulated by the MACRA.
    - Continue the efforts to promote and stabilize APMs

- Medicare Payments Struggling to Cover Practice Costs
  - With the exception of the 2020-2024, Medicare physician payments in Part B have largely remained stagnant over the last two decades.
  - The delta between the cost of running a practice as measured by the MEI is growing.
  - Hospitals (outpatient and inpatient) have seen their payments steadily increase because they have a rate of inflation incorporated into their payment system.
  - Policy Solution: Permanent, annual payment update tied to the MEI.

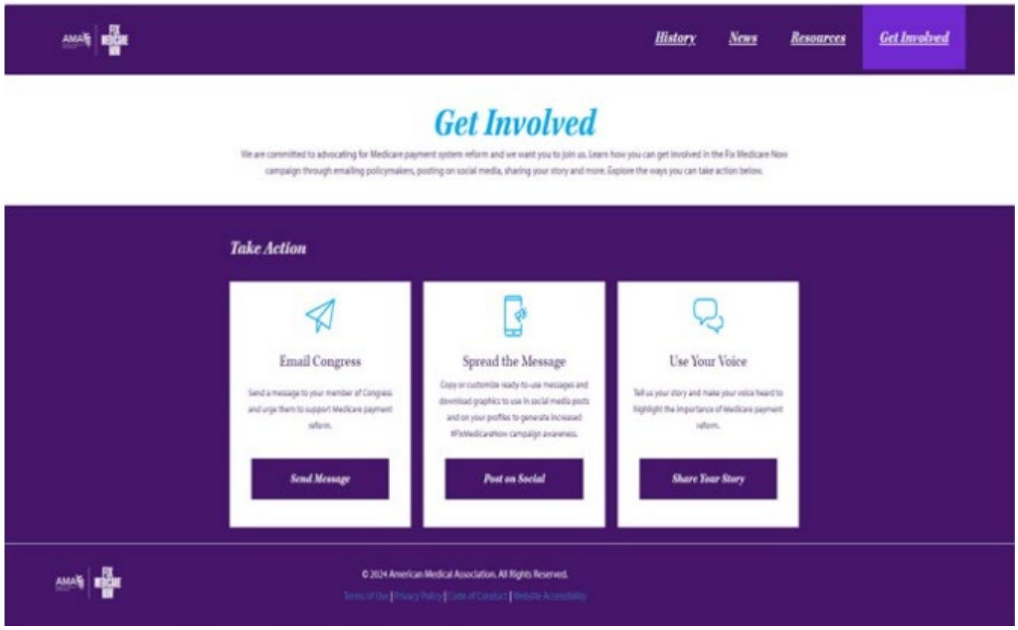




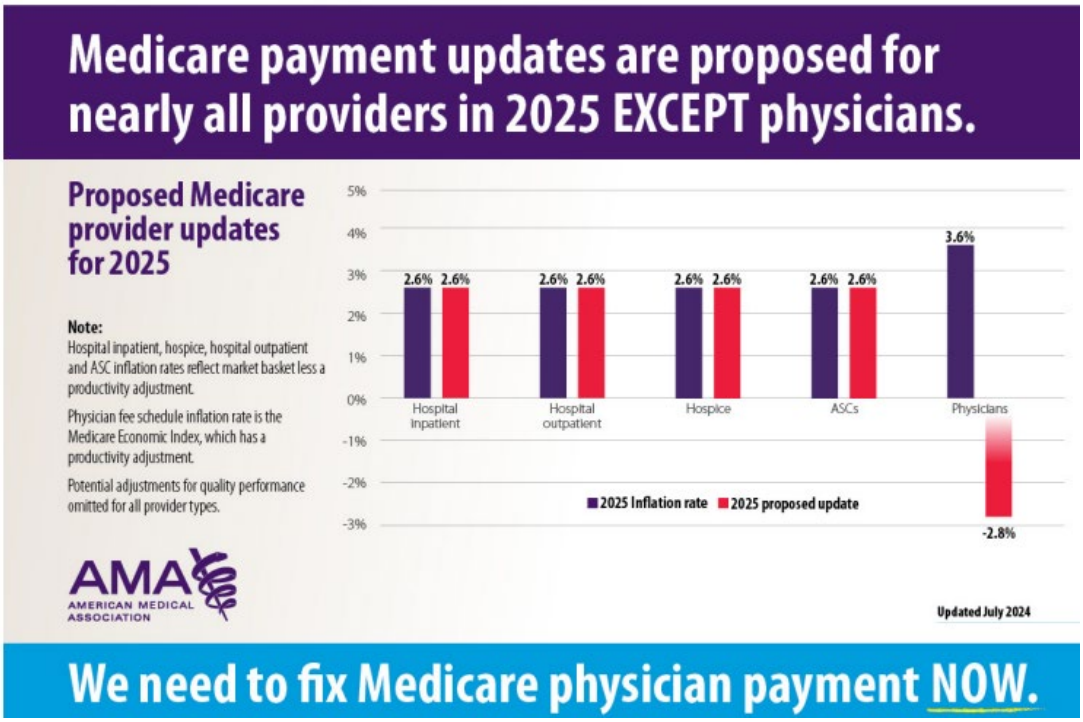
- Cost of MEI Components Grew between 2020 and 2024
  - The impact of a lack of an MEI increase has become more pronounced as inflation has increased.
  - CMS estimates MEI increase of 3.6% in the CY25 MFS Proposed Rule (4.6% in CY 24).
  - Historically, MEI is between 1- 2%.

- H.R. 2474, the Strengthening Medicare for Patients and Providers Act
    - To help bring much needed stability to the payment system, AMA is pushing Congress to enact H.R. 2474 because it provides physicians with a permanent, annual inflationary update in Medicare.
    - Outside of this essential fix, the legislation addresses the conversion factor changes in 2026.
        - In 2026, MACRA stipulates that MIPS participants receive annual 0.25% increases, while APM participants receive annual 0.75% increases.
        - Bill stipulates that the MEI would replace the differential conversion factor (i.e., only MEI and not MEI + 0.25%/0.75%).
    - Legislation currently has more than 160 bipartisan cosponsors (119 Dems, 42 Reps)
        - 2024 Medicare Trustees Report (and many past reports) have stated that continuation of current payment trajectory will lead to access to care issues for beneficiaries
        - 2023-2024 MEDPAC Reports have called for physicians to get an inflationary update tied to the MEI.

- Grassroots Activity Needed Now!
    - Please log onto FixMedicareNow.org to contact your Members of Congress and urge them to cosponsor H.R. 2474!



- New Year, Same Sad Payment Story
    - In addition to the poor historic payment trends, physicians, once again, are potentially facing a cut in Medicare reimbursement due to expiration of past legislative fixes that stopped budget neutrality cuts stemming from evaluation and management service changes.
    - Effective 1/1/25, the MFS CF will be lowered by 2.8% ($33.29 to $32.36)
    - Since physicians have no financial margins to accept annual cuts, AMA is fighting back!

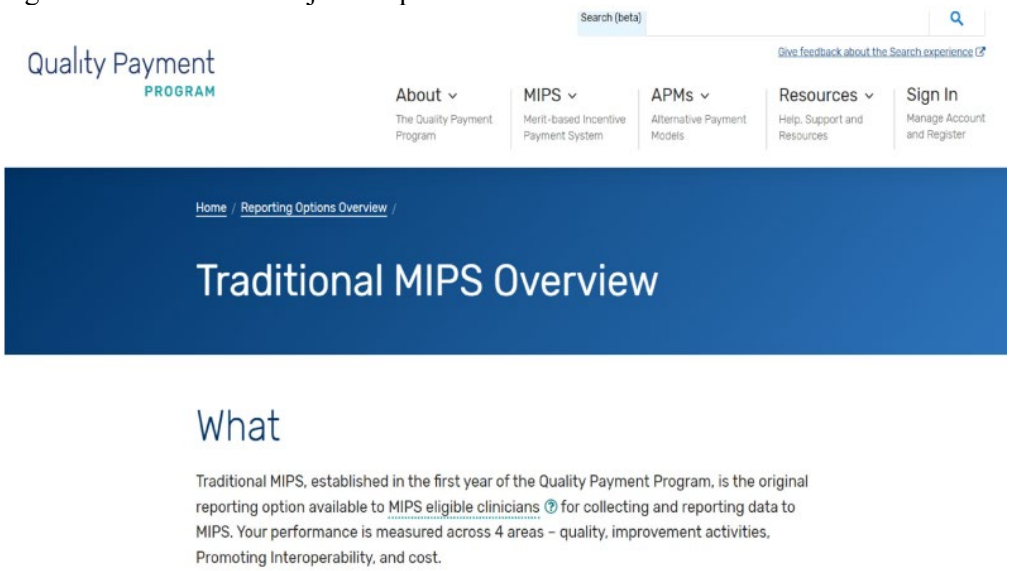


- House Bipartisan Dear Colleague Letter
  - Reps. Mariannette Miller-Meeks, MD (R-IA, EC) and Jimmy Panetta (D-CA, WM) wrote a letter to House leadership urging Congress stop the 2.8% cut AND provide an inflationary update before 1/1/25.
  - Other co-leads include
    - Greg Murphy, MD (R-NC, WM)
    - Raul Ruiz, MD (D-CA, EC)
    - Larry Bucshon, MD (R-IN, EC)
    - Kim Schrier, MD (D-WA, EC)
    - John Joyce, MD (R-PA, EC)
    - Ami Bera, MD (D-CA)
  - Letter closed with TONS of bipartisan cosigners!

- Budget Neutrality Reforms
  - Along with stopping the 2.8% cut and providing an inflationary update, AMA is also pushing legislation to reform statutory provisions governing budget neutrality in the MFS.
  - Under current law, a uniform budget neutrality adjustment is applied across all services to ensure that changes to Relative Value Units (RVUs) for existing services do not affect expenditures by more than $20 million.
    - In other words, if RVU changes lead to increases or decreases in $20 million, other parts of the MFS have to be adjusted in a corresponding manner.
    - Recent budget neutrality adjustments stem from E/M RVU changes and G2211.
  - This threshold, along with other key components of the MFS, are creating substantial payment swings for physicians.
  - To stop these wild swings and bring more certainty to the process, AMA introduced legislation to reform budget neutrality.

- H.R. 6371, the Provider Reimbursement Stability Act
  - Section 2: Update the budget neutrality threshold from $20 million to $53 million. Plus, starting in 2030 and not less than every 5 years, the threshold will be increased by the cumulative MEI increase.
  - Section 3: Prospective budget neutrality corrections for over/under utilization estimates.
  - Section 4: This section requires CMS to review all direct inputs for PE RVUs at the same time and no less often than every 5 years. Direct inputs for PE RVUs include clinical wages, prices of medical supplies, and prices of equipment.
  - Section 5: Prevent the MPFS Conversion Factor from increasing or decreasing by more than 2.5% in a given year.
    - Intent is for CF changes to continue to occur in succeeding years but language is largely silent on this fact to give CMS needed flexibility.
    - The 0.25% MIPS CF increases and 0.75% APM CF increases, as well as any future MEI increases, would be exempt from the 2.5% cap.
  - All of these complex policy changes were developed by AMA in consultation with the Federation. Portions of the bill (Sects. 2 & 4) were passed by E&C in Dec. 2023 in H.R. 6545.

- AMA Legislation to Reform MIPS
  - If that wasn't enough, AMA is also pushing for the introduction of House/Senate legislation to overhaul major components of MIPS!



- Why Do We Need Legislation?
  - 2021 JAMA Study: MIPS compliance costs $12,800 and 53 hours, per physician, per year.
  - 2022 JAMA Study: MIPS scores are inconsistently related to performance and suggests MIPS program is approximately as effective as chance in terms of identifying high vs. low performance.
  - More than 45% of MIPS solo eligible clinicians (ECs), 31% of ECs in small practices, and 18% of rural practices received a MIPS penalty in 2024 compared to fewer than 14% of ECs, overall.
  - More than 27% of solo ECs and 12% of small practice ECs received the maximum penalty of 9% compared to 2% ECs, overall.

- Data-Driven Performance Payment System (DPPS)
    - AMA's MIPS overhaul consists of three main themes:
        - Freeze the current Composite Score threshold at 60 points for three years (2025-2028), direct Government Accountability Office (GAO) to study a new composite score and mandate CMS promulgate new regulations based on the recommendations (if no new legislation is enacted), and eliminate the tournament model.
            - +/- 9% replaced with payments that equate to a percentage of the "payment update"– either the .25% or, if H.R. 2474 passes, the MEI–based on performance in MIPS.
            - Policy is designed to be budget neutral.
            - No physicians would be penalized….period, full stop
        - To ensure MACRA statute is met and to help physicians better achieve successful scores, require CMS to provide three quarters worth of claims data during the performance year.
            - Failure to provide data results in NO MIPS penalties assessed on physician.
        - Overhaul the quality measurement process with an emphasis on enabling the Cost and Quality categories to develop new, meaningful measures; simplify the Promoting Interoperability category.
    - No House or Senate legislation…..yet.

- Alternative Payment Models
    - Earlier this year, Congress included language in the CAA, 24 that would extend the APM incentive payments but only at 1.88%. Bill also froze the revenue threshold needed to even qualify for the bonuses at 50%.
    - AMA, in conjunction with the Alliance for Value-based Patient Care, still pushing for an extension of the 1.88% bonus and the frozen revenue threshold for an additional 12-months.
    - Legislation to continue these important policy proposals will likely be considered as part of lame duck.

- Congressional Committees of Jurisdiction Exploring Payment Reform
    - 10/19/23: House Energy and Commerce Health Subcommittee hearing entitled, "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Physicians."
        - Numerous health care bills passed out of Energy and Commerce
    - 4/11/24: Senate Finance Committee hearing entitled, "Bolstering Chronic Care through Medicare Physician Payment."
    - 5/17/24: Senate Finance Committee releases White Paper entitled, "Bolstering Chronic Care Through Physician Payment and Policy Options in Medicare Part B."
        - Senate Finance Committee members formed a separate "working group" on payment reform.
    - 5/23/24: House Ways and Means Full Committee hearing: "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine."
    - Bipartisan, bicameral Committee leadership sending positive messages that they want to stop the cut and explore comprehensive Medicare physician payment reform. Expect action in lame duck.

- Temporary Extension of Telehealth Flexibilities
    - It is widely expected that Congress, during the lame duck session, will also temporarily extend the COVID-19 telehealth flexibilities.
    - 5/8/24- The House Ways and Means Committee passed H.R. 8261, the Preserving Telehealth, Hospital, and Ambulance Access Act.
    - 9/18/24- The House Energy and Commerce Committee passed H.R. 7623, the Telehealth Modernization Act.
        - Health Subcommittee passed bill on 5/16/24.
    - AMA supports both bills that: 1) suspend geographic and originating site restrictions; 2) continue moratorium on requirement for an in-person visit within 6 months of the first telemental health visit; 3) continue CMS authority to provide audio-only options; 4) extend the hospital-at-home program for 5 years.
    - No action yet from Senate Finance but extension all but assured to happen in lame duck. Estimated cost of 2-year extension is $4 billion.

- Improving Seniors' Timely Access to Care Act
    - Last Congress, the Improving Seniors' Timely Access to Care Act, garnered more than 300 bipartisan cosponsors and easily passed the House.
        - Bill died in the Senate due to a $16 billion Congressional Budget Office (CBO) Score attributed to provisions mandating more timely Prior Authorization (PA) decisions for "routinely approved," "emergent," and "all other Part C services."
        - Biden Administration finalizes an e-prior authorization regulation in 2024 that encompasses much of the PA legislation. Lowers the score down to $4 billion since added to the baseline.
    - 6/12/24- lawmakers reintroduced H.R. 8702/S. 4532, the Improving Seniors' Timely Access to Care Act, but without stiffer deadlines for Medicare Advantage (MA) plans to issue PA decisions.
        - Bill still gives explicit authority to CMS to require more timely PA decisions, but no longer required in legislative language.
    - Hopeful that the restructured bill will score $0 and easily pass Congress in lame duck.

- Conclusion
    - AMA will continue to fight to stop short-term payment cuts, as well as pursue passage of H.R. 2474, H.R. 6371, and continuation of the APM bonuses.
    - AMA will also continue to push for introduction of DPPS legislation.
    - Cautiously optimistic that action on telehealth and prior authorization is also possible in 2024 lame duck session.
    - All of these legislative efforts will not be easy
    - But, with the combined efforts of all physicians, we can achieve success!

- Ms. Hananoki and Mr. Sherin addressed questions from attendees:
    - A RUC member thanked Ms. Hananoki for pointing out to CMS the added burden of HCPCS II codes (ie, "G" codes). The disproportionate burden on primary care is challenging so it would be preferred if physicians could work with CMS and the CPT Editorial Panel to create CPT codes for needed services which would be very helpful to lessen this significant burden related to reporting services.
    - A RUC member stated that in 1998, the conversion factor was $36.6973. Using the Federal Reserve's inflation calculator, $1 is worth $1.93 today, so the 2024 conversion factor (using inflation) should be $70.8065. Given this information and the remarks on

H.R. 2474, is there a chance that there could be action related to an inflationary adjustment to the Medicare conversion factor in the lame duck session? Mr. Sherin responded that the current form of H.R. 2474 is unlikely to pass. The CBO score is quite high, however, approximately 300 billion for 65 million Medicare beneficiaries not that large when put into context. Additionally, the AMA continues to push for an inflationary update that is permanent to reflect the costs of practicing medicine today. When asking for these types of permanent changes, then we need to provide "offsets" of where the money will come from to supplement the inflationary update.

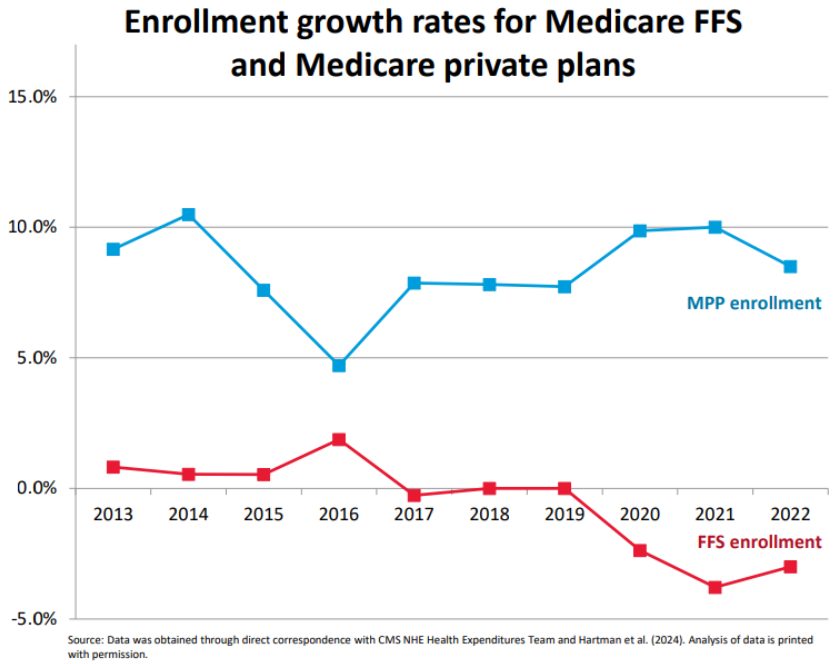
- A RUC member stated that as new services are added to the MFS, other services are subject to budget neutrality constraints. Further, we are seeing private equity and other larger entities coming in and purchasing smaller groups so the majority of doctors are now employed which distorts the funding and Congress needs to recognize this. Mr. Sherin responded that the increase in private equity in healthcare is a concern on the Hill, however, the AMA is focused on trying to ensure that independent physicians have as many opportunities as possible to stay independent. Further, the AMA Practice Benchmark Survey which looked at data from 2012 to 2022 has shown for the first time that the majority of physicians are employed and they are not in independent practice and that trend is concerning to policymakers, however the legislative outcome is still unclear.

IX. Medicare FFS Spending Growth

Apoorva Rama, PhD, AMA Senior Economist, provided data on Medicare fee-for-service (FFS) Spending Growth with a focus on Medicare Physician Payment Schedule (MFS) services, tracking broad measures of MFS spending, and assessing G2211 spending and utilization in 2024 Q1.

- Medicare FFS Environment
  - Pandemic and recovery
  - Changes in pay
    - Legislative changes in the physician update
    - Redistribution with changes to RBRVS
  - Changes in utilization patterns
    - Faster growth for some services and specialties
  - Changes in enrollment

- Enrollment growth rates for Medicare FFS and Medicare private plans

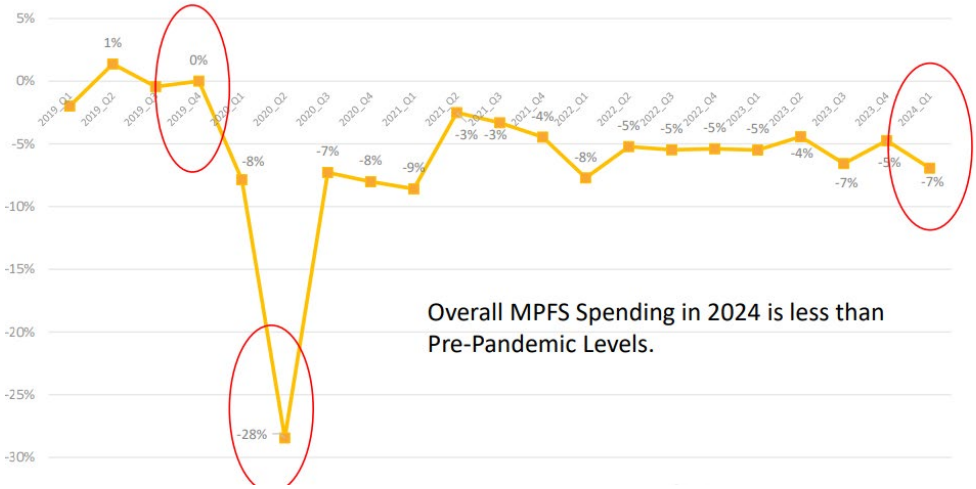


  - Medicare private plans (MPP) are growing much faster than Medicare fee-for-service (FFS)
  - Avg Annual Growth Rates (2013-2022)
    - Enrollment: -0.6% for FFS vs. 8.3% for MPP
    - Spending per Enrollee: 2.0% for FFS vs. 3.2% for MPP
    - Spending: 1.4% for FFS vs. 11.7% for MPP
  - Shares of spending (2013 vs. 2022)
    - In 2013, 72% of Medicare spending was from FFS while only 28% was from MPP
    - By 2022, only 50% of Medicare spending was from FFS and 50% was from MPP
    - In 2022, 45.8% of Medicare beneficiaries are MPP enrollees but they account for half the total Medicare spending

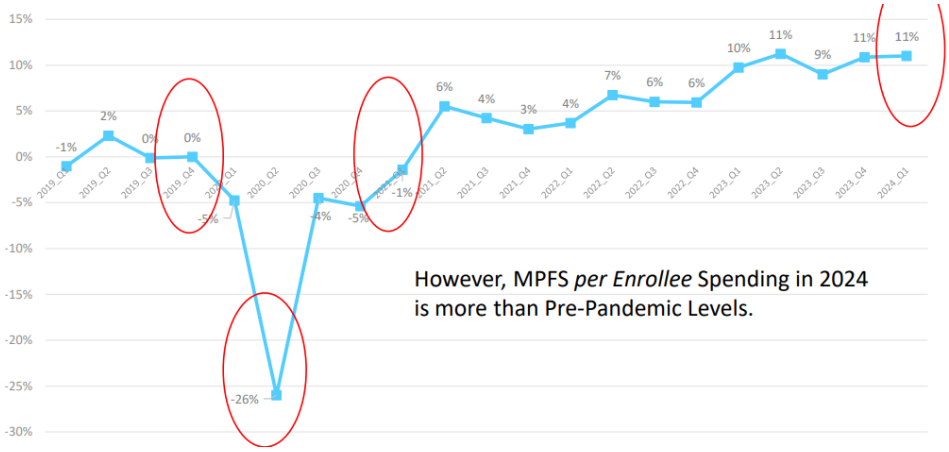
- Spending Growth and Pandemic Recovery (2019 to 2024)

- Data
  - Claims data for a 5% sample of Medicare FFS beneficiaries are available through CMS
    - Quarterly data files are available through 2024 Q1
    - Results are scaled to reflect the Part B FFS population

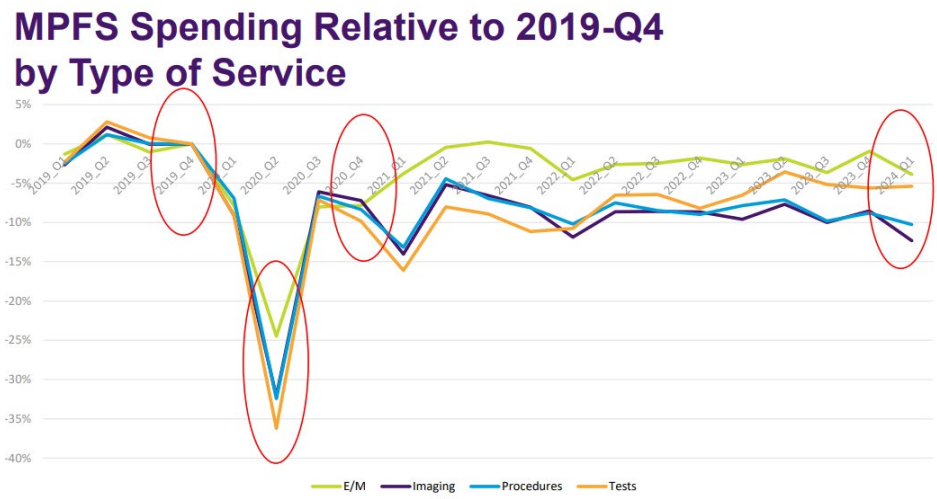
- MFS Spending by Quarter Relative to 2019-Q4



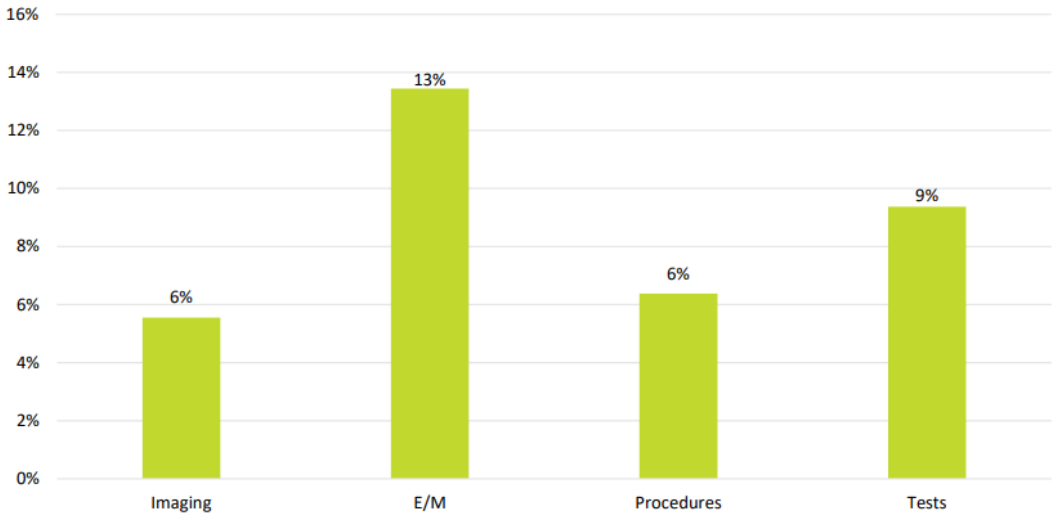
- MFS Spending *Per Enrollee* by Quarter Relative to 2019-Q4



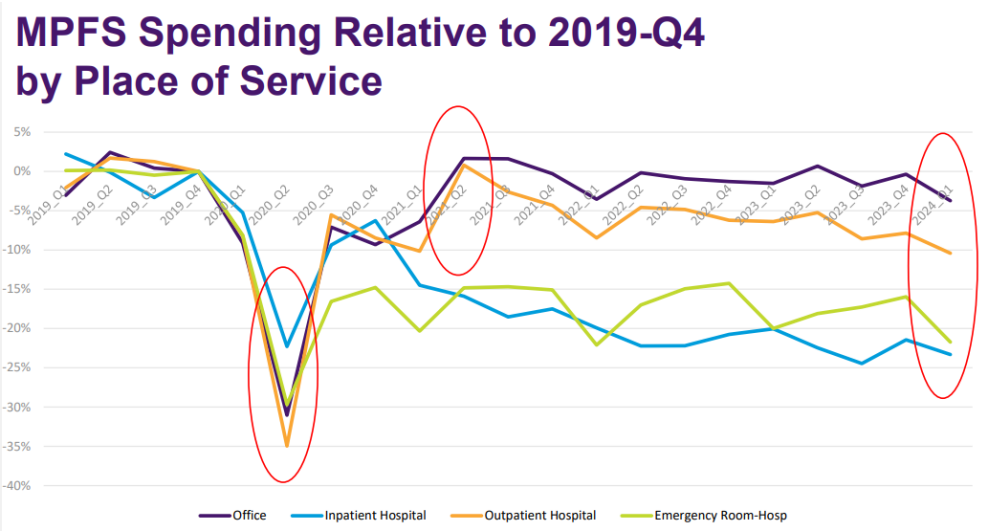
- MFS Spending Relative to 2019-Q4 by Type of Service



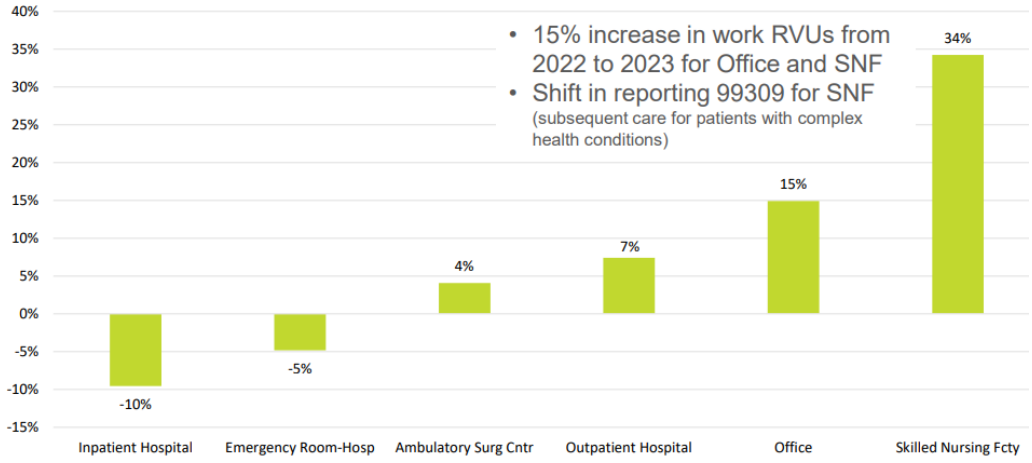
- MFS Spending *Per Enrollee* Growth 2019-2023 by Type of Service



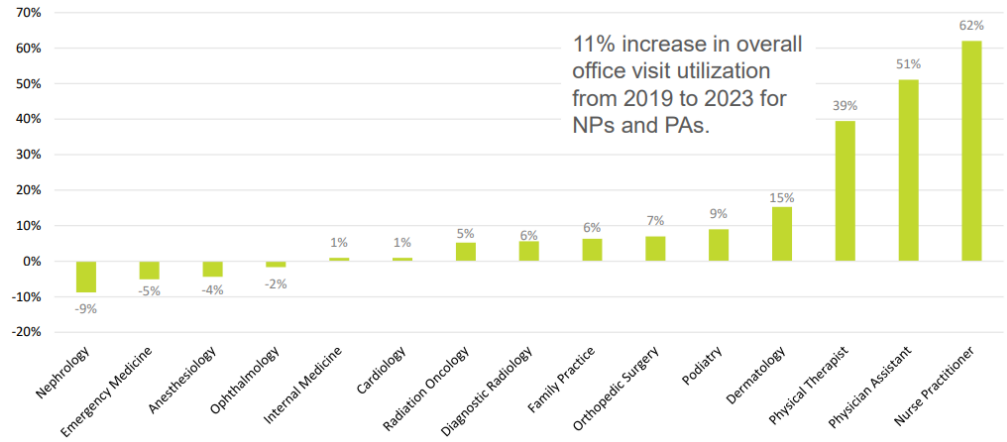
- MFS Spending Relative to 2019-Q4 by Place of Service



- MFS Spending *Per Enrollee* Growth 2019-2023 by Place of Service



- MFS Spending *Per Enrollee* Growth 2019-2023 by Specialty



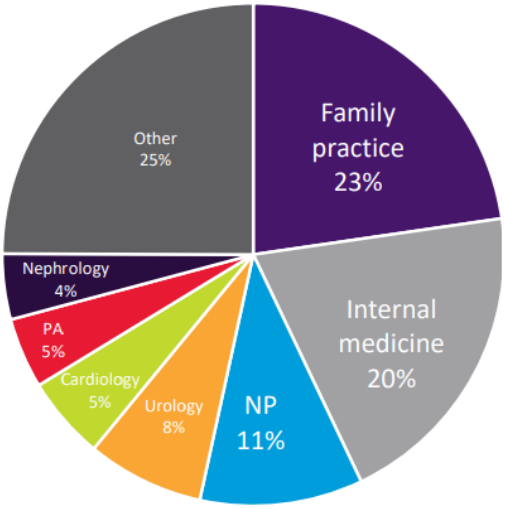
- G2211 (2024-Q1) Overview
  - G2211 is the add-on code (for Office E/M visits) that reflects the complexity of a patient visit when it's part of an ongoing care relationship.
  - 2024-Q1 Claims data for a 5% sample of Medicare FFS beneficiaries is used to assess the utilization of G2211.
    - The results are scaled to reflect the Part B FFS population.
    - The results are shown for both Q1 AND scaled to reflect the full year
      - The latter is done for comparison purposes but must be taken with a grain of salt as there are differences across quarters AND differences in adoption after rollout.
    - This is NOT a definitive analysis on the impact of G2211. This is a preview.
      - The Physician/Supplier Procedure Summary File (PSPS) and Annual Claims Data for 2024 won't be available until Fall 2025.
      - Additional quarters of 2024 data will likely be available by April 2025.

- G2211 Utilization and Spending

	1st Quarter, 5% Claims (Actual)	1st Quarter, FFS Population (Estimate)	First Year, FFS Population (Estimate)	CMS 2022 Estimate
Utilization	178K	3.6M	14.2M	83.7M
Spending	$2.8M	$56.4M	$0.2B	$1.3B

  - This suggests CMS estimated G2211 utilization to be 6x the actual use.
  - G2211 utilization relative to eligible Office E/M utilization is 6.7%.
    - For every 100 Office E/M services provided, G2211 is added ~7 of those times.
  - Final Rule CY2024 estimates "G2211 will be billed with 38 percent of all O/O E/M visits"

- G2211 Utilization by Specialty

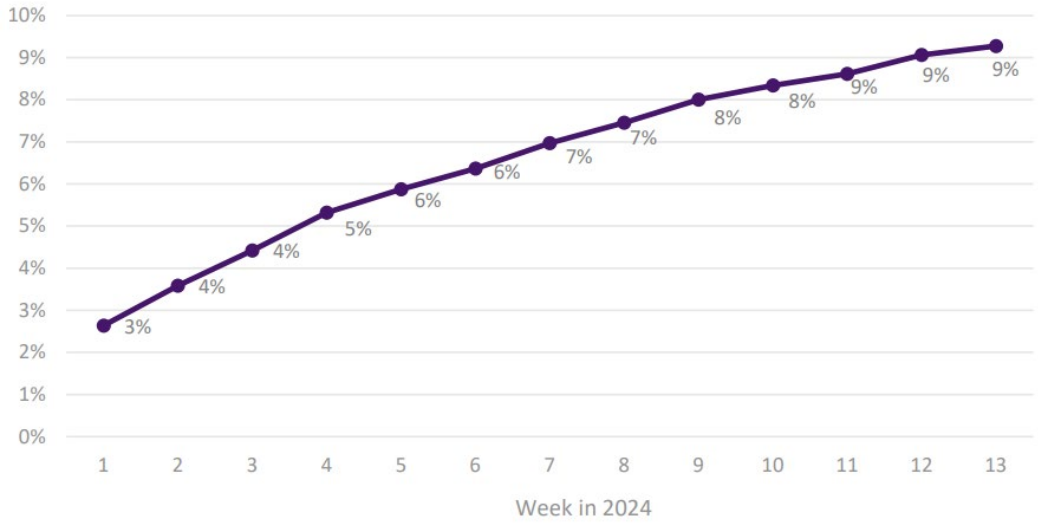


- G2211 Utilization Relative to Office E/M by Specialty
  - G2211 utilization relative to eligible Office E/M utilization is 6.7%. For specialties that utilized G2211 the most:
    - Family practice: 13%
      - For every 100 Office E/M services provided by a family practice physician, 13 of those times had G2211 added on.
    - Internal medicine: 12%
    - Nurse practitioner: 5%
    - Urology: 18%
    - Cardiology: 7%
    - Physician assistant: 4%
    - Nephrology: 21%

- G2211 Utilization Relative to Office E/M by State
  - G2211 utilization relative to eligible Office E/M utilization is 6.7%. But there were differences across states.

  - States with the lowest rates:
    - Wyoming: 2%
    - Alaska: 2%
    - Vermont: 3%
    - Connecticut: 3%
  - States with the highest rates:
    - South Carolina: 11%
    - Oregon: 10%
    - Mississippi: 10%
    - North Carolina: 10%
  - For every 100 Office E/M services provided in Wyoming, 2 of them had the G2211 add-on
  - States with the most Office E/M:
    - California: 5%
    - Florida: 6%
    - Texas: 7%
    - New York: 7%

- G2211 Utilization Relative to Office E/M by Week
  - G2211 utilization relative to eligible Office E/M utilization is 6.7%. But there were differences throughout the quarter.



- Wrap-Up
  - Quarterly Claims Data shows
    - Pandemic Recovery (2019-2024): FFS per enrollee spending is greater than before the pandemic.
    - Spending and Utilization (2019-2023):
      - E/M saw more growth compared to other type of service categories.
      - SNF and Offices saw more growth compared to other place of services.
      - Nurse Practitioners (NPs) and Physician Associates (PAs) saw more growth compared to other specialties.
    - G2211 (2024-Q1): Utilization of this code is significantly less than expected, but still growing.

- Dr. Rama addressed questions from attendees:
    - A RUC member commented that when funds are "lost" from the MFS given incorrect utilization assumptions, that money is never returned to the payment schedule and CMS needs to be very cognizant about that. Further, it is essential that we have the Medicare Advantage data so that the AMA, RUC, and others are able to use this data in decision-making and to ensure that there aren't significant payment distortions between traditional Medicare and Medicare Advantage.
    - A RUC member requested clarification if the G2211 exclusions were taken into account within the dataset such as performing a minor office visit and using the 25 modifier which would exclude the use of G2211. Dr. Rama responded that was taken into account when conducting the analysis.
    - A RUC member requested clarification on the impact of G2211 on the conversion factor. Dr. Rama responded that if you were to look at the conversion factor from year to year, there are two things that happen: a budget neutrality adjustment and a physician update. For example, the budget neutrality adjustment was approximately a 2% decline. So, 90% of that 2% decline was impacted by the introduction of G2211. The RUC member stated that the prediction of the utilization was six times more than that, therefore, if the CMS utilization estimate had been correct, that cut would have been smaller. AMA staff stated that CMS finalized a 38% utilization assumption, and the AMA and specialty societies advocated for a lower utilization assumption of 10%. However, CMS finalized the 38% utilization assumption which directly led to the 2% conversion factor cut. Therefore, if they had instead used 6-10% as suggested by stakeholders, it would have been a 0.33% cut instead of 2%.
    - A RUC member inquired about AMA access to Medicare Advantage data and if there is an understanding of how much of the spending goes toward administrative overhead versus actual patient care to the beneficiaries. Dr. Rama responded that we do not have access to this data set. However, earlier this year MedPAC released an analysis using the existing sources of Medicare Advantage encounter data and noted that there is a lack of transparency with the datasets as the records were often incomplete, etc. Dr. Rama highlighted that it is an ongoing issue and it is an active request of many entities across healthcare to have access to higher quality, and transparent Medicare Advantage utilization data.
    - A RUC member requested forecasting related to future utilization of G2211 and the impact on the conversion factor. Dr. Rama responded that the AMA focuses on analyzing what is available and not future forecasting since there are a number of variable components at play.
    - A RUC member requested the Evaluation and Management (E/M) utilization data for Physician Assistants and Nurse Practitioners be split out by specialty for better interpretation of the data. Dr. Rama mentioned that she would keep this in mind for future analysis. Two other RUC members supported this data breakdown to ensure that utilization assumptions are correct, practice patterns are tracked, and to ensure that funding is funneled to the appropriate areas within medicine.

X. Relative Value Recommendations for CPT 2026

<u>Limb Lengthening/Shortening-Femur (Tab 4)</u>
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Kevin Neal, MD (AAOS)

In May 2024, the CPT Editorial Panel created a new Category I code, 27458, for reporting femur lengthening using the insertion of an externally controlled intramedullary lengthening device, including imaging. Though lengthening of long bones is a well-established treatment for clinically significant limb inequalities, the emergence of this new technology has fundamentally changed the preoperative planning, intraoperative technical requirements, and postoperative management for these lengthening procedures. CPT code 27458 and the other codes within this code family, including 27465, 27466, and 27468, were surveyed for the September 2024 RUC Meeting.

Compelling Evidence
The RUC agreed with the specialty society that there is compelling evidence to support a change in physician work for CPT codes 27465 and 27466 based on the argument that there was a flawed mechanism or methodology used in the previous evaluation. In their summary of recommendation, the specialty society articulated that pediatric orthopaedic surgeons (who typically perform the service on children with congenital limb length discrepancies) were not involved nor was their input included in the original valuation of these services. The RUC recognized that the survey conducted for the September 2024 RUC Meeting included orthopaedic pediatric surgeons, along with general and trauma orthopaedic surgeons, who are all experienced in orthopaedic reconstructive surgery and experienced in performing these low-volume procedures. **The RUC agrees with the compelling evidence presented that the physician work for these services has changed based on evidence that incorrect assumptions were made in the previous valuation of these services.**

27458 ***Osteotomy(ies), femur, unilateral, with insertion of an externally controlled intramedullary lengthening device, including iliotibial band release when performed, imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device***
The RUC reviewed survey results from 46 orthopaedic surgeons and determined the survey median work RVU of 26.65 appropriately accounted for the physician work required to perform this service. The RUC recommends 50 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 180 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99215, 1-99214, and 6-99213 visits for this service, which equals 621 minutes of total time.

The specialty society selected pre-service time package 3 *FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The selected time packages were modified to more accurately reflect pre-and post-service time involved with this service. The additional 17 minutes of pre-service evaluation time above the standard pre-time package time of 33 minutes accounts for the additional time necessary for tasks including preoperative discussion with the patient's parents regarding the surgery and review/obtain informed consent; reexamination of the patient to ensure that the physical findings have not changed by reviewing imaging and confirming prior measurements related to device selection; sterile setup of the intramedullary lengthening device and sterile testing of the remote controller magnetic field generator for proper function before implantation; and verification that other hardware required for this service is available. The specialty society confirmed that 17 additional minutes of pre-service

evaluation time is consistent and maintains relativity with other reconstructive device-intensive codes and operations on children within the Medicare Physician Payment Schedule. An additional 12 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for padding of bony prominences, positioning and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging equipment during surgery. The specialty society confirmed that 12 additional minutes of pre-service positioning time is consistent with femur procedures.

The RUC agreed with the surveying society that the post-operative office visits typically involve assessing the progress of ambulation and counseling the family regarding wound care, therapy protocol, and review of narcotic pain medication. For CPT code 27458, the physician will also interpret the radiographs and confirm the calculation for the planned lengthening protocols, as well as update the external remote controller (ERC) device programming.

To justify a work RVU value of 26.65, the RUC compared CPT code 27458 to top key reference service and 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 = 26.80, 180 minutes intra-service time and 509 minutes total time) and the second highest key reference service 27284 *Arthrodesis, hip joint (including obtaining graft);* (work RVU = 25.06, 180 minutes intra-service time and 497 minutes total time). The RUC recognizes that the surveyed code is an appropriate comparator relative to the two key reference services, bracketing the survey median work RVU and having identical intra-service time. For additional support, the RUC referenced MPC code 54438 *Replantation, penis, complete amputation including urethral repair* (work RVU = 24.50, 180 minutes intra-service time and 531 minutes total time) noting that this service requires similar physician work and has identical intra-service time as the surveyed code. **The RUC recommends a work RVU of 26.65 for CPT code 27458.**

27465 *Osteoplasty, femur; shortening (excluding 64876)*
The RUC reviewed survey results from 38 orthopaedic surgeons and determined the survey median work RVU of 21.13 appropriately accounted for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 143 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99214, and 3-99213 visits for this service, which equals 450 minutes of total time.

The specialty society selected pre-service time package *3 FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The selected time packages were modified to more accurately reflect pre-and post-service time involved with this service. The additional 7 minutes of pre-service evaluation time above the standard pre-time package time of 33 minutes accounts for the additional time necessary for tasks including reexamination of the patient to ensure that the physical findings have not changed (range of motion of the hip and knee, neurovascular status, length and rotation of the limb); precise pre-operative marking, including confirmation of the harvest location of bone graft; and verification that other hardware required for this service are available. Less pre-service evaluation time is required for this service compared to CPT code 27458 because this service does not require the preliminary steps required for using the externally controlled intramedullary lengthening device, including sterile testing of the device. An additional 12 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for padding of bony prominences, positing and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging

equipment during surgery. The specialty society confirmed that 12 additional minutes of pre-service positioning time is consistent with femur procedures.

The RUC agreed with the survey specialty society that the post-operative visits typically involve standard procedures such as assessing the progress of ambulation and counseling the family regarding wound care, therapy protocol, and review of narcotic pain medication. Fewer follow-up office visits are required for CPT code 27465 because there is no reprogramming of the device and controller.

To justify a work RVU value of 21.13, the RUC compared CPT code 27465 to top key reference service 27244 *Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage* (work RVU = 18.18, 75 minutes intra-service time and 438 minutes total time) and the second highest key reference service and MPC code 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 22.09, 150 minutes intra-service time and 479 minutes total time). The RUC recognizes that the surveyed code is an appropriate comparator relative to the two key reference services, bracketing the survey median work RVU, as well as in terms of intra-service time and intra-operative intensity. For additional support, the RUC referenced MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service time and 404 minutes total time), noting that this reference code requires similar intra-service time and has a nearly identical work RVU as the survey median. **The RUC recommends a work RVU of 21.13 for CPT code 27465.**

27466 *Osteoplasty, femur; lengthening*
The RUC reviewed survey results from 30 orthopaedic surgeons and determined the survey median work RVU of 22.65 appropriately accounted for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 150 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99214, and 3-99213 visits for this service, which equals 457 minutes of total time.

The specialty society selected pre-service time package 3 *FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The selected time packages were modified to more accurately reflect pre-and post-service time involved with this service. The additional 7 minutes of pre-service evaluation time above the standard pre-time package time of 33 minutes accounts for the additional time necessary for tasks including reexamination of the patient to ensure that the physical findings have not changed (range of motion of the hip and knee, neurovascular status, length and rotation of the limb); precise pre-operative marking, including confirmation of the harvest location of bone graft; and verification that other hardware required for this service are available. Like CPT code 27465, less pre-service evaluation time is required for this service compared to CPT code 27458 because this service does not require the preliminary steps required for using the externally controlled intramedullary lengthening device, including sterile testing of the device. The additional 12 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for padding of bony prominences, positing and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging equipment during surgery. The specialty society confirmed that 12 additional minutes of pre-service positioning time is consistent with femur procedures.

The RUC agreed with the survey specialty society that the post-operative visits typically involve standard procedures such as assessing the progress of ambulation and counseling the family regarding

wound care, therapy protocol, and review of narcotic pain medication. Fewer follow-up office visits are required for CPT code 27466 because there is no reprogramming of the device and controller.

To justify a work RVU value of 22.65, the RUC compared CPT code 27466 to top key reference service 27280 *Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed* (work RVU = 20.00, 120 minutes intra-service time and 383 minutes total time) and the second highest key reference service and MPC code 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 22.09, 150 minutes intra-service time and 479 minutes total time). The RUC recognizes that the surveyed code is an appropriate comparator relative to the two key reference services. The surveyed code requires identical intra-service time to the second key reference service and is bracketed by the two reference services in terms of total time and as well physician work.

For additional support, the RUC referenced MPC code 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service time and 512 minutes total time), noting that this reference code requires identical intra-service time as the surveyed code, though the greater work RVU is attributable to the MPC code, which is more intense and complex to perform. **The RUC recommends a work RVU of 22.65 for CPT code 27466.**

RUC Referral to CPT Editorial Panel
27468 *Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer*
The specialty society submitted a letter to request that CPT code 27468 be contractor priced. The survey was sent to a random sample of 2,201 members and an additional random sample of 602, however, the specialty society was unable to meet the survey minimum threshold of 30 responses. The specialty society letter indicated that the work of both shortening one leg and lengthening the contralateral leg is quite variable. Proper reporting of this work should instead be based on the procedures performed as there are several methods for both shortening and lengthening that may be utilized based on the discrepancy of leg length, the age and comorbidities of the patient, and the pathology associated with the leg length discrepancy. Moreover, the specialty society recommends that CPT code 27468 be sent to CPT for deletion in CY 2027. **The RUC recommends contractor pricing for CPT code 27468 and that the specialty society submit a CCA to the CPT Editorial Panel to delete CPT code 27468 for CY 2027.**

Practice Expense
The Practice Expense (PE) Subcommittee concurred that there is compelling evidence to support an increase over the aggregate current cost for clinical staff time, supplies and equipment for the code family based on changes in physician time due to changes in the number/level of post-operative visits, per the survey, and consequent increases in equipment time.

The PE Subcommittee reviewed the direct practice expense inputs for CPT codes 27458, 27465 and 27466, and made no modifications to the standard 090-day global inputs. The PE Subcommittee noted that CPT code 27468 has no recommended PE inputs as the recommendation is to have this code be contractor priced until it can be deleted through a CPT code application. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology
CPT code 27458 will be placed on the New Technology list to be reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

Limb Lengthening/Shortening-Tibia (Tab 5)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Kevin Neal, MD (AAOS)

In May 2024, the CPT Editorial Panel created a new Category I code, 27713, for reporting tibia lengthening using the insertion of an externally controlled intramedullary lengthening device, including imaging. Though lengthening of long bones is a well-established treatment for clinically significant limb inequalities, the emergence of this new technology has fundamentally changed the preoperative planning, intraoperative technical requirements, and postoperative management for these lengthening procedures. CPT code 27713 and the other code within this code family 27715, were surveyed for the September 2024 RUC Meeting.

Compelling Evidence
The RUC agreed with the specialty society that there is compelling evidence to support a change in physician work for CPT code 27715 based on the argument that there was a flawed methodology used in the previous evaluation. In their summary of recommendation, the specialty society articulated that pediatric orthopaedic surgeons (who typically perform the service on children with congenital limb length discrepancies) were not involved nor was their input included in the original valuation of this service. The RUC recognized that the survey conducted for the September 2024 RUC meeting included orthopaedic pediatric surgeons, along with general and trauma orthopaedic surgeons who are all experienced in orthopaedic reconstructive surgery and experienced in performing these low-volume procedures. **The RUC agrees with the compelling evidence presented that the physician work for these services has changed based on evidence that incorrect assumptions were made in the previous valuation of these services.**

27713 ***Osteotomy(ies), tibia, including fibula when performed, unilateral, with insertion of an externally controlled intramedullary lengthening device, including imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device***
The RUC reviewed survey results from 45 orthopaedic surgeons and determined the survey median work RVU of 28.00 appropriately accounted for the physician work required to perform this service. The RUC recommends 50 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 200 minutes intra-service time, 30 minutes immediate post-service time, 1-99231, 1-99232, 1-99238, 6-99213, 1-99214 and 1-99215 visits for this service, which equals 641 minutes of total time.

The specialty society selected pre-service time package *3 FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The selected time packages were modified to more accurately reflect pre-and post-service time involved with this service. The additional 17 minutes of pre-service evaluation time above the standard pre-time package time of 33 minutes accounts for the additional time necessary for tasks including preoperative discussion with the patient's parents regarding the surgery and review/obtain informed consent; reexamination of the patient to ensure that physical findings have not changed to review imaging and confirm prior measurements related to device selection; sterile setup of the intramedullary lengthening device and sterile testing of the remote controller magnetic field generator

for proper function before implantation; and verification that other hardware required for this service or available. The specialty society confirmed that 17 additional minutes of pre-service evaluation time is consistent with other device-intensive codes and operations on children. An additional 12 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for padding of bony prominences, positioning and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging equipment during surgery. The specialty society confirmed that 12 additional minutes of pre-service positioning time is consistent with femur procedures.

The RUC agreed with the surveying society that the post-operative office visits typically involve assessing the progress of ambulation and counseling the family regarding wound care, therapy protocol, and review of narcotic pain medication. For CPT code 27713, the physician will also interpret the radiographs and confirm the calculation for the planned lengthening protocols, as well as update the external remote controller (ERC) device programming.

To justify a work RVU value of 28.00, the RUC compared CPT code 27713 to top key reference service and 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 = 26.80, 180 minutes intra-service time and 509 minutes total time) and the second highest key reference service and MPC code 27284 *Arthrodesis, hip joint (including obtaining graft);* (work RVU = 25.06, 180 minutes intra-service time and 497 minutes total time). The RUC recognizes that the surveyed code is an appropriate comparator relative to the two key reference services, bracketing the survey median work RVU, as well as in terms of intra-service time and intraoperative intensity. For additional support, the RUC referenced MPC codes 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 25.18, 198 minutes intra-service time and 466 minutes total time) and 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (work RVU = 43.28, 205 minutes intra-service time and 776 minutes total time), noting that together these two codes also bracket the survey median work RVU and have identical intra-service time as the surveyed code. **The RUC recommends a work RVU of 28.00 for CPT code 27713.**

27715 ***Osteoplasty, tibia and fibula, lengthening or shortening***
The RUC reviewed survey results from 45 orthopaedic surgeons and determined the survey median work RVU of 22.50 appropriately accounted for the physician work required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes scrub/dress/wait time, 150 minutes intra-service time, 30 minutes immediate post-service time, 1-99231, 1-99232, 1-99238, 3-99213 and 1-99214 visits for this service, which equals 457 minutes of total time.

The specialty society selected pre-service time package 3 *FAC Straightforward Patient/Difficult Procedure* and post-service time package *9B General Anes or Complex Regional Blk/Cmplx Proc*. The selected time packages were modified to more accurately reflect pre-and post-service time involved with this service. The additional 7 minutes of pre-service evaluation time above the standard pre-time package time of 33 minutes accounts for the additional time necessary for tasks including reexamination of the patient to ensure that the physical findings have not changed (range of motion of the hip and knee, neurovascular status, length and rotation of the limb); precise pre-operative marking, including confirmation of the harvest location of bone graft; and verification that other hardware required for this service are available. Less pre-service evaluation time is required for this service compared to CPT code 27713 because this service does not require the preliminary steps required for using the externally controlled intramedullary lengthening nails device, including sterile

testing of the device. The additional 12 minutes of pre-service positioning time is required above the standard package time of 3 minutes to account for padding of bony prominences, positing and bolstering the patient's leg to allow for surgical exposure and manipulation of the limb and imaging equipment during surgery. The specialty society confirmed that 12 additional minutes of pre-service positioning time is consistent with femur procedures.

The RUC agreed with the surveying society that these follow-up office visits typically involve standard procedures such as assessing the progress of ambulation and counseling the family regarding wound care, therapy protocol, and review of narcotic pain medication. Fewer office visits are required for CPT code 27715 than 27713 because there is no reprogramming of the device and controller.

To justify a work RVU value of 22.50, the RUC compared CPT code 27715 to top key reference service 27269 *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed* (work RVU = 18.89, 125 minutes intra-service time and 404 minutes total time) and the second highest key reference service and MPC code 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;* (work RVU = 22.09, 150 minutes intra-service time and 479 minutes total time). The RUC recognizes that the surveyed code is an appropriate comparator relative to the two key reference services, bracketing the survey median work RVU, as well as in terms of intra-service time and intraoperative intensity. For additional support, the RUC referenced MPC code 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* (work RVU = 23.53, 150 minutes intra-service time and 502 minutes total time), noting that this reference code requires similar intra-service time and has similar physician work as the surveyed code. **The RUC recommends a work RVU of 22.50 for CPT code 27715.**

Practice Expense
The Practice Expense (PE) Subcommittee concurred that there is compelling evidence to support an increase over the aggregate current cost for clinical staff time, supplies and equipment for the code family based on changes in physician time due to changes in the number/level of post-operative visits, per the survey, and consequent increases in equipment time.

The PE Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. The PE Subcommittee noted that the use of the 12-minute standard for CA036 *Discharge day management* is appropriate. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology
CPT code 27713 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation, patient population, and utilization assumptions.

<u>Laparoscopic Prostatectomy (Tab 6)</u>
Eilean Attwood, MD (ACOG), Seth Cohen, MD (AUA), Jon Hathaway, MD (ACOG), Jonathan Kiechle, MD (AUA)

In April 2023, the Relativity Assessment Workgroup identified CPT codes 38571 and 55866 as typically reported together 75% or more based on 2021 Medicare claims data. In September 2023, the RUC recommended that 38571 and 55866 be referred to the CPT Editorial Panel to possibly develop a code bundling solution. In May 2024, the CPT Editorial Panel created two new codes to report laparoscopic prostatectomy with lymph node biopsy(ies) (limited pelvic lymphadenectomy) and with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes,

respectively. The societies surveyed codes 55840-55845, 55846-55847 and 55868-55869 for the September 2024 RUC meeting.

Prostatectomy for prostate cancer requires complete removal of the prostate and seminal vesicles. Careful dissection and preservation of the neurovascular bundles coursing along the contour of the prostate in an attempt to limit post-operative side effects, including urinary incontinence and erectile dysfunction and careful posterior dissection, to prevent rectal injury in a narrow anatomic space. Following excision of the prostate, the bladder and urethra are reconstructed to allow appropriate passage of urine through the urethra without urinary extravasation into the abdomen. Lymphadenectomy requires removal of all lymph tissue distal to the bifurcation of the common iliac and extending into the obturator fossa surrounding the obturator nerve and extending to the pubic bone.

Code Family
The specialty societies indicated that CPT codes 38570, 38571, 38572, and 38573 are predominately performed by gynecological oncology and obstetrics/gynecology, with the exception of CPT code 38571. While CPT code 38571 is currently reported by urologists 85% of the time, 82% of these claims are reported together with 55866. CPT code 38571 will switch to a code rarely reported by urologists due to the creation of bundled codes 55868 and 55869. The RUC discussed whether CPT codes 38570-38573 should be affirmed or whether they should be considered separately from codes 55840-55847, 55868 and 55869. **The RUC agreed that 38570-38573 should not be reviewed with this family of services and instead should be flagged for review by the RAW in April 2028, when 2026 utilization data are available.**

Pre-operative and Post-operative care
Each service in this code family (55840-55847; 55868-55869) typically requires 15 minutes of pre-service positioning time. This time is warranted to prepare and drape abdomen and genitalia, pad the patient's wrists, elbows, shoulders, and legs, the place, test sequential compression devices, tuck the patient's arms under sheets place the patient in a slightly hyperextended supine position and pad all pressure points.

Further, each procedure described in this code family except for 55867 typically requires two 99214 post-operative office visits. During both post-operative office visits, moderate medical decision making takes place. At each visit, the evaluation of undiagnosed new problems with uncertain prognoses and the management of chronic illness with progression or side effects of treatment are addressed. During the first visit, pathology results and next steps for prostate cancer management are discussed. Furthermore, interventions of moderate risk of morbidity take place during both post-operative visits, including prescription and drug management. The risks, benefits, and potential side effects of medications are discussed for penile rehabilitation for post-operative erectile dysfunction and potential medication management for urinary incontinence. The option of pelvic floor physical therapy for urinary incontinence is also discussed. During the second post-op office visit, results of a prostate-specific antigen (PSA) test are typically evaluated to determine the successful nature of the cancer operation.

55840 ***Prostatectomy, retropubic radical, with or without nerve sparing;***
The RUC reviewed the survey results from 33 urologists and determined that the current work RVU of 21.36, which falls below the survey 25th percentile, appropriately accounts for the physician work to perform this service. The RUC recommends 30 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 180 minutes intra-service time, 25 minutes immediate post-service time, 1 x 99232 post-operative hospital visit, 1x 99238 discharge visit and 2x 99214 post-operative office visits. The RUC noted that although the number of

post-operative visits slightly decreased, the level of respective post-operative visits increased. Even though the total time decreased, the average intensity of that post-operative care increased; therefore, maintaining the current value would be appropriate.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU= 22.10, intra-service time of 150 and total time of 404) and noted that the surveyed code includes more intra-service time and total time. The RUC also compared the surveyed code to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU= 19.53, intra-service time of 180 minutes and total time of 383 minutes) and noted that although both services typically involve the same amount of intra-service time, the surveyed code typically involves 35 more minutes of total time. The RUC recommended times and values for the surveyed code would assign it a work intensity that is identical to code 42420. **The RUC recommends a work RVU of 21.36 for CPT code 55840.**

55842 ***Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)***The RUC reviewed the survey results from 33 urologists and determined that the current work RVU of 21.36, which falls below the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 30 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 200 minutes intra-service time, 25 minutes immediate post-service time, 1 x 99232 post-operative hospital visit, 1 x 99238 discharge visit and 2 x 99214 post-operative office visits.

Although this service also includes a limited lymphadenectomy (unlike 55840), the specialties noted that CMS has maintained the same value for this code relative to 55840 for over a decade and noted that the additional work required for performing a limited lymphadenectomy is relatively negligible for this low volume code. Therefore, the specialty proposed, and the RUC agreed, that it would be appropriate to maintain the current value for this service.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU= 22.10, intra-service time of 150 and total time of 404) and noted that the surveyed code includes more intra-service time and total time. **The RUC recommends a work RVU of 21.36 for CPT code 55842.**

55845 ***Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes***
The RUC reviewed the survey results from 34 urologists and determined that the current work RVU of 25.18, which falls below the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 34 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 210 minutes intra-service time, 25 minutes immediate post-service time, 1 x 99232 post-operative hospital visit, 1 x 99238 discharge visit and 2 x 99214 post-operative office visits.

The specialty noted that the utilization of 55845 has decreased significantly over the past ten years from 2,296 claims in 2012 to 497 claims in 2022. This change in utilization has been driven by the wide adoption of robotic surgical instruments for pelvic surgery over the past decade. This decrease in utilization has led to increased complexity and intensity when performing the open procedure, due to the decreasing frequency with which the open procedure is performed. This change in utilization helps explain the increase in intra-service time identified in the survey.

To support the recommended work RVU, 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= 26.60, intra-service time of 180 minutes, total time of 424) and noted that the surveyed code involves more intra-service time and total time and that both major surgical procedures are typically performed in the inpatient setting. The RUC acknowledged the limited number of potential reference codes that are major surgical procedures with similar service period times and physician work, limiting the pool of potential reference codes. **The RUC recommends a work RVU of 25.18 for CPT code 55845.**

55866 ***Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed;***
The RUC reviewed the survey results from 72 urologists and determined that the current work RVU of 22.46, which falls below the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 200 minutes intra-service time, 45 minutes immediate post-service time, 0.5 x 99238 discharge visit and 2 x 99214 post-operative office visits. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. The RUC noted that, due to the code structure change, a majority of the former volume for 55866 will instead be reported with new bundled codes 55868 and 55869 going forward.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 43335 *Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis* (work RVU= 23.97, intra-service time of 200 minutes, total time of 569 minutes) and noted that both services involve the same amount of intra-service time, whereas the reference code involves more total time. The RUC also compared the surveyed code to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU= 19.53, intra-service time of 180 minutes and total time of 383 minutes) and noted that the surveyed code is appropriately valued higher as it typically involves more intra-service and total time. **The RUC recommends a work RVU of 22.46 for CPT code 55846.**

55868 ***Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with lymph node biopsy(ies) (limited pelvic lymphadenectomy)***
The RUC reviewed the survey results from 69 urologists and determined that the current work RVU of 22.46 from 55866 (the primary code bundled into 55868), which falls below the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The specialty noted and the RUC concurred that the increase in work to biopsy the pelvic nodes without complete dissection, is a minimal increase in work and intensity relative to 55866. The specialty noted and the RUC concurred that 55868 is significantly less intense than the full lymph node dissection code 55869, which requires complete circumferential mobilization of the external iliac vessels and complete identification and mobilization of the obturator nerve. Therefore, the specialty proposed and the RUC agreed that it would be appropriate to use the current value for 55866, which is being bundled into 55868, as the new value for the new code as well.

The RUC recommends 35 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 210 minutes intra-service time, 45 minutes immediate post-service time, 0.5 x 99238 discharge visit and 2 x 99214 post-operative office visits. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 43335 *Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis* (work RVU= 23.97, intra-service time of 200 minutes, total time of 569 minutes) and noted that although the surveyed code typically involves 10 more minutes of intra-service time, the reference code involves more total time and is appropriately valued more. The RUC also compared the surveyed code to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU= 19.53, intra-service time of 180 minutes and total time of 383 minutes) and noted that the surveyed code is appropriately valued higher as it typically involves more intra-service and total time. **The RUC recommends a work RVU of 22.46 for CPT code 55868.**

55869 ***Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes***
The RUC reviewed the survey results from 71 urologists and determined a direct work RVU crosswalk to CPT code 27059 *Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater* (work RVU= 29.35, intra-service time of 220 minutes) appropriately accounts for the work required to perform this service. Both services typically involve a similar amount of intra-service time and the same overall amount of physician work. The RUC recommends 35 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 230 minutes intra-service time, 50 minutes immediate post-service time, 0.5x 99238 discharge visit and 2x 99214 post-operative office visits. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

The specialty noted and the RUC concurred that CPT code 55869 is significantly more intense than the partial lymph node dissection code 55868, as a complete extended bilateral pelvic lymph node dissection adds significant technical complexity and intensity to robotic prostatectomy as nodes must be carefully removed from the external iliac vessels, the area surrounding the obturator nerve, and proximally to the bifurcation of the common iliac. This dissection requires significant care and explains the increase in intra-service time for this procedure compared to 55868.
The RUC noted that the current value for 55869 would be the full value of 55866 and half the value of 38572 due to a surgical multiple procedure payment reduction (a total of 28.46). The RUC noted that the intra-service time of this bundled code is higher, and the average intensity of the post-operative care has increased.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 58575 *Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed* (work RVU= 32.60, intra-service time of 240 minutes, total time of 510 minutes) and noted that the reference code is appropriately valued somewhat higher due to it involving somewhat more intra-service time and more total time. The RUC also compared the surveyed code to CPT code 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU= 30.10, intra-service time of 210 minutes, total time of 454 minutes) and noted that although the surveyed code typically involves more intra-service time, the reference code involves somewhat more total time. **The RUC recommends a work RVU of 29.35 for CPT code 55869.**

55867 ***Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed***
The RUC reviewed the survey results from 61 urologists and determined that the current work RVU of 19.53, which falls below the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 180 minutes intra-service time, 50 minutes immediate post-service time, 0.5 x 99238 discharge visit, 1 x 99214 and 1 x 99213 post-operative office visit. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical.

To support the recommended work RVU, the RUC compared the surveyed code to CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* (work RVU= 22.10, intra-service time of 150 and total time of 404) and noted that the surveyed code includes more intra-service time and total time, though is somewhat less intense to perform. The RUC also compared the surveyed code to CPT code 42420 *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* (work RVU= 19.53, intra-service time of 180 minutes and total time of 383 minutes) and noted that although both services typically involve the same amount of intra-service time and a similar amount of total time. The RUC recommended times and values for the surveyed code would assign it a work intensity that is identical to code 42420. **The RUC recommends a work RVU of 19.53 for CPT code 55867.**

RAW Flag
The RUC recommends that CPT codes 38570, 38571, 38572 and 38573 be reviewed by the Relativity Assessment Workgroup in April 2028 when 2026 Medicare utilization data is available to review new claims data. This will follow the implementation of bundled codes 55868 and 55869 and determine which specialties are reporting 38570-38573, the patient population, and typical diagnoses for each code.

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

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.

<u>Transurethral Robotic-assisted Resection of Prostate (Tab 7)</u>
Seth Cohen, MD (AUA), Jonathan Kiechle, MD (AUA)

In April 2023, the Relativity Assessment Workgroup (RAW) identified CPT code 0421T via the high-volume Category III codes screen with Medicare utilization over 1,000. The RAW requested an action plan for the September 2023 RUC meeting to determine if a Category I code should be created. In September 2023, the RAW recommended that this service be referred to the CPT Editorial Panel. In May 2024, the CPT Editorial Panel created a new Category I code to report transurethral robotic-assisted waterjet resection of the prostate, including ultrasound guidance. The existing Category III code and related parentheticals were deleted. The code family was surveyed for the September 2024 RUC meeting.

52500 ***Transurethral resection of bladder neck (separate procedure)***
The RUC reviewed the survey results from 57 urologists and determined that the survey 25th percentile work RVU of 6.00 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes pre-service evaluation time, 7 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 30 minutes intra-service time, 15 minutes immediate post-service time, 0.5-99238, 1-99214 and 1-99213, which totals 169 total minutes. The pre-service positioning time was increased from the pre-service time package of 3 minutes to 7 minutes as indicated by the survey respondents to account for placing the patient in the dorsal-lithotomy position. The RUC noted some variability of the pre-service positioning and scrub/dress/wait time across this family of codes but maintained the standard not to exceed times as indicated by the survey respondents.

This service is typically performed in the hospital setting. However, most patients are discharged on the same day, thus a half discharge day management visit is appropriate. The survey respondents indicated two post-operative office visits are necessary following this procedure. The RUC agreed with the specialty societies that the two post-operative office visit levels are one 99213 and one 99214. During the 99214 post-operative office visit, issues of moderate complexity, including the management of chronic illness with progression or side effects of treatment are addressed. The urinary catheter is removed. Typically following catheter removal, patients will develop urinary incontinence as their external urethral sphincter becomes solely responsible for the maintenance of continence following the opening up of the prostate or bladder neck. Patients also will typically have significant dysuria requiring significant counseling that this is a normal and expected outcome, secondary to the destruction or removal of prostate adenoma. The physician also discusses interventions of moderate risk, including prescription drug management. Prescription drug management is required to discuss and offer patients medications, including anticholinergic or beta-3 agonist medications to help limit post-operative symptoms within the 90-day global period. During the 99213 post-operative office visit, the physician will again discuss prescription drugs, change doses, and address side effects. However, the decision-making complexity is low with the management of a stable chronic illness.

This procedure is a resection of the bladder neck that requires the surgeon to work in a narrow space between the trigone of the bladder and the ureteral orifices and the hypertrophied bladder neck to relieve the patient's urinary obstruction. A cystoscope is inserted into the bladder through the penis and an electrical current is typically used to resect the hypertrophied bladder neck to relieve the patient's obstructive symptoms. Significant care must be taken to ensure the ureters are not injured, and to ensure that the bladder neck, while resected, is also preserved, and not perforated. Following the conclusion of the resection, care must be taken to ensure all tissue chips and blood clots are removed from the bladder to avoid obstruction of the urinary catheter.

The RUC compared the surveyed code to the top key reference code 53854 *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (work RVU = 5.93, 25 minutes intra-service time and 137 minutes total time) and determined that these services require similar physician work and time to perform and are valued appropriately relative to one another. The RUC compared the surveyed code to the second top key reference service 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time) and determined that the surveyed service requires less physician work and time to perform and thus is appropriately valued lower. For additional support, the RUC referenced MPC code 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46, 30 minutes intra-service time and minutes 246.5 minutes total time), which requires more total time, thus valued higher. The RUC determined that the survey 25th percentile work value of 6.00 appropriately places CPT code 52500 relative to other services in the

Medicare Physician Payment Schedule (MFS) based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 6.00 for CPT code 52500.**

52597 ***Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, when performed***

The RUC reviewed the survey results from 50 urologists and determined that the survey 25th percentile work RVU of 10.25 appropriately accounts for the work required to perform this service. The RUC recommends 32 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238, 1-99214 and 1-99213, which totals 234 minutes. The pre-service positioning time was increased from the pre-service time package of 3 minutes to 10 minutes as indicated by the survey respondents to account for placing the patient in the dorsal-lithotomy position and positioning of the robotic arm and the transrectal ultrasound.

This service is typically performed in the hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. The RUC confirmed that the immediate post-service time of 40 minutes appropriately accounts for the immediate care of the patient (20 minutes), as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day. The survey respondents indicated that they perform a 99232 hospital visit and the RUC determined that the time should be captured in the immediate post-service time.

The survey respondents indicated that two post-operative office visits are necessary following this procedure. The RUC agreed with the specialty societies that the two post-operative office visits levels are one 99213 and one 99214. During the 99214 post-operative office, visit issues of moderate complexity, including the management of chronic illness with progression or side effects of treatment are addressed. The urinary catheter is removed. Typically following catheter removal, patients will develop urinary incontinence as their external urethral sphincter becomes solely responsible for the maintenance of continence following the opening up of the prostate or bladder neck. Patients also will typically have significant dysuria requiring significant counseling that this is a normal and expected outcome, secondary to the destruction or removal of prostate adenoma. The physician also discusses interventions of moderate risk, including prescription drug management. Prescription drug management is required to discuss and offer patients medications, including anticholinergic or beta-3 agonist medications to help limit post-operative symptoms within the 90-day global period. During the 99213 post-operative office visit, the physician will again discuss prescription drugs, change doses, and address side effects. However, the decision-making complexity is low with the management of a stable chronic illness.

This procedure requires precise ultrasound mapping of the contour of the prostate to ensure adequate waterjet resection without perforation of the prostate capsule, undermining of the bladder neck, or damage to the external urethral sphincter. Real-time ultrasound guidance is used throughout the robotic ablation process to ensure procedural success and patient safety. Following the conclusion of the waterjet resection, care must be taken to ensure adequate hemostasis using a resectoscope and cautery. All tissue chips and blood clots must be removed from the bladder, or the catheter will become obstructed causing discomfort and potential bladder perforation.

To support the survey 25th percentile work RVU of 10.25, the RUC compared the surveyed code to MPC codes 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time) and 57250 *Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time), noting that these services all require the same intra-service time of 60 minutes and similar physician work.

For additional support, the RUC referenced MPC codes 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46, 30 minutes intra-service time and minutes 246.5 minutes total time) and 54437 *Repair of traumatic corporeal tear(s)* (work RVU = 11.50, 60 minutes intra-service time and 264 minutes total time), which brackets the surveyed code. The RUC determined that the survey 25th percentile work value of 10.25 appropriately places CPT code 52597 relative to other services in the MFS based on time, work, intensity, and complexity**. The RUC recommends a work RVU of 10.25 for CPT code 52597.**

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)***
The RUC reviewed the survey results from 60 urologists and determined that the survey 25th percentile work RVU of 10.00 appropriately accounts for the work required to perform this service. The RUC recommends 26 minutes pre-service evaluation time, 7 minutes pre-service positioning time, 7 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238, 1-99214 and 1-99213, which totals 222 minutes. The pre-service positioning time was increased from the pre-service time package of 3 minutes to 7 minutes as indicated by the survey respondents to account for placing the patient in the dorsal-lithotomy position. The RUC noted some variability of the pre-service positioning and scrub/dress/wait time across this family of codes, however maintained the standard not to exceed times as indicated by the survey respondents.

This service is typically performed in the hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. The RUC confirmed that the immediate post-service time of 40 minutes appropriately accounts for the immediate care of the patient (20 minutes) as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day. The survey respondents indicated that they perform a 99232 hospital visit and the RUC determined that the time should be captured in the immediate post-service time.

The survey respondents indicated that two post-operative office visits are necessary following this procedure. The RUC agreed with the specialty societies that the two post-operative office visits levels are one 99213 and one 99214. During the 99214 post-operative office visit, issues of moderate complexity, including the management of chronic illness with progression or side effects of treatment are addressed. The urinary catheter is removed. Typically following catheter removal, patients will develop urinary incontinence as their external urethral sphincter becomes solely responsible for the maintenance of continence following the opening up of the prostate or bladder neck. Patients also will typically have significant dysuria requiring significant counseling that this is a normal and expected outcome, secondary to the destruction or removal of prostate adenoma. The physician also discusses interventions of moderate risk, including prescription drug management. Prescription drug management is required to discuss and offer patients medications, including anticholinergic or beta-3 agonist medications to help limit post-operative symptoms within the 90-day global period. During the 99213 post-operative office visit, the physician will again discuss prescription drugs, change doses, and

address side effects. However, the decision-making complexity is low with the management of a stable chronic illness.

This procedure is intense throughout as the prostatic urethra sits between the trigone of the bladder and the external urethral sphincter. Care must be taken to prevent damage to the external sphincter, which can result in significant stress urinary incontinence, and prevent damage to the trigone of the bladder and the ureters. Care must also be taken to preserve the bladder neck as undermining of the bladder neck can lead to significant complications including urinary extravasation. Following the conclusion of the resection, care must be taken to ensure all tissue chips are removed from the bladder or the catheter will become obstructed causing discomfort and potential bladder perforation.

To support the survey 25th percentile work RVU of 10.00, the RUC compared the surveyed code to MPC codes 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time) and 57250 *Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time), noting that these services all require the same intra-service time of 60 minutes and similar physician work. The RUC noted that 52601 also requires the same intra-service time and similar physician work as the 52597 in this family of services and should be valued similarly.

For additional support, the RUC referenced MPC codes 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46, 30 minutes intra-service time and minutes 246.5 minutes total time) and 54437 *Repair of traumatic corporeal tear(s)* (work RVU = 11.50, 60 minutes intra-service time and 264 minutes total time) and determined that together these services bracket the surveyed code. The RUC determined that the survey 25th percentile work value of 10.00 appropriately places CPT code 52601 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 10.00 for CPT code 52601.**

52630 ***Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)***
The RUC reviewed the survey results from 60 urologists and determined that given that there is no compelling evidence to indicate there has been a recent change in physician work, the RUC recommends maintaining the current work RVU of 6.55 for this service. The RUC recommends 26 minutes pre-service evaluation time, 7 minutes pre-service positioning time, 7 minutes pre-service scrub/dress/wait time, 50 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238, 1-99214 and 1-99213, which totals 212 minutes. The pre-service positioning time was increased from the pre-service time package of 3 minutes to 7 minutes as indicated by the survey respondents to account for placing the patient in the dorsal-lithotomy position. The RUC noted some variability of the pre-service positioning and scrub/dress/wait time across this family of codes, however maintained the standard not to exceed times as indicated by the survey respondents.

This service is typically performed in the hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. The RUC confirmed that the immediate post-service time of 40 minutes appropriately accounts for the immediate care of the patient (20 minutes) as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day. The survey respondents indicated that they perform a 99232 hospital visit and the RUC determined that the time should be captured in the immediate post-service time.

The survey respondents indicated that two post-operative office visits are necessary following this procedure. The RUC agreed with the specialty societies that the two post-operative office visits levels are one 99213 and one 99214. During the 99214 post-operative office visit, issues of moderate complexity, including the management of chronic illness with progression or side effects of treatment are addressed. The urinary catheter is removed. Typically following catheter removal, patients will develop urinary incontinence as their external urethral sphincter becomes solely responsible for the maintenance of continence following the opening up of the prostate or bladder neck. Patients also will typically have significant dysuria requiring significant counseling that this is a normal and expected outcome, secondary to the destruction or removal of prostate adenoma. The physician also discusses interventions of moderate risk, including prescription drug management. Prescription drug management is required to discuss and offer patients medications, including anticholinergic or beta-3 agonist medications to help limit post-operative symptoms within the 90-day global period. During the 99213 post-operative office visit, the physician will again discuss prescription drugs, change doses, and address side effects. However, the decision-making complexity is low with the management of a stable chronic illness.

The specialty societies indicated that the 10-minute decrease in intra-service time is most likely due to the diffusion of improved resection technology for completing transurethral resection of the prostate adding validity to the survey information. During the 50 minutes of intra-service, the intensity is the same throughout the procedure. A cystoscope is inserted into the bladder through the penis and an electrical current is used to resect residual or regrown prostate tissue following prior procedural intervention to relieve the patient's obstruction. This procedure typically is more intense, though performed in a shorter period of time due to the re-operative nature of the procedure. While less tissue typically has to be removed, the prostate does not regrow in a smooth or normal expected anatomic way following prior procedural intervention, and the surgeon must be careful to correctly identify regrown tissue compared to bladder, locate the ureters, and ensure that the resection performed safely to relieve the obstruction. Furthermore, the proliferation of bladder outlet procedure technologies has increased the complexity for the typical patient undergoing this re-operative restriction.

The RUC compared the surveyed code to the top key reference code 53854 *Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy* (work RVU = 5.93, 25 minutes intra-service time and 137 minutes total time) and determined the surveyed code requires twice as much intra-service time and more physician work to resect the residual or regrowth of obstructive prostate tissue, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, thus should be valued higher.

For additional support, the RUC compared the surveyed code to MPC codes 26113 *Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater* (work RVU = 7.13, 58 minutes intra-service time and 214 minutes total time) and 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46, 30 minutes intra-service time and minutes 246.5 minutes total time) and determined that the current work value of 6.55 appropriately places CPT code 52630 relative to other services in the MFS based on time, work, intensity and complexity. **The RUC recommends a work RVU of 6.55 for CPT code 52630.**

52647 ***Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/ or dilation, and internal urethrotomy are included if performed)***

The specialty societies noted that the utilization of CPT code 52647 has always been low and continues to decline, with only 90 claims in the 2022 Medicare data. Additionally, the specialty society understands that the manufacturer of the device for laser coagulation of the prostate, which is used in services reported by CPT code 52647, is no longer making the necessary device. Given the low volume

of 52647, the code could not be surveyed and properly valued within the code family. Therefore, AUA submitted a code change application (CCA) requesting the deletion of CPT code 52647 which was considered at the September 2024 CPT Editorial Panel meeting. **The CPT Editorial Panel approved the request to delete CPT code 52647 for CPT 2026.**

52648 ***Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/ or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)***
The RUC reviewed the survey results from 47 urologists and determined that the survey 25th percentile work RVU of 10.05 appropriately accounts for the work required to perform this service. The RUC recommends 32 minutes pre-service evaluation time, 7 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, 35 minutes immediate post-service time, 0.5-99238, 1-99214 and 1-99213, which totals 226 minutes. The pre-service positioning time was increased from the pre-service time package of 3 minutes to 7 minutes as indicated by the survey respondents to account for placing the patient in the dorsal-lithotomy position. The RUC noted some variability of the pre-service positioning and scrub/dress/wait time across this family of codes, however maintained the standard not to exceed times as indicated by the survey respondents.

This service is typically performed in the hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. The RUC confirmed that the immediate post-service time of 35 minutes appropriately accounts for the immediate care of the patient (15 minutes) as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day.

The targeted survey respondents indicated that two post-operative office visits are necessary following this procedure. The RUC agreed with the specialty societies that the two post-operative office visits levels are one 99213 and one 99214. During the 99214 post-operative office visit, issues of moderate complexity, including the management of chronic illness with progression or side effects of treatment are addressed. The urinary catheter is removed. Typically following catheter removal, patients will develop urinary incontinence as their external urethral sphincter becomes solely responsible for the maintenance of continence following the opening up of the prostate or bladder neck. Patients also will typically have significant dysuria requiring significant counseling that this is a normal and expected outcome, secondary to the destruction or removal of prostate adenoma. The physician also discusses interventions of moderate risk, including prescription drug management. Prescription drug management is required to discuss and offer patients medications, including anticholinergic or beta-3 agonist medications to help limit post-operative symptoms within the 90-day global period. During the 99213 post-operative office visit, the physician will again discuss prescription drugs, change doses, and address side effects. However, the decision-making complexity is low with the management of a stable chronic illness.

To complete this procedure, a cystoscope is inserted into the bladder through the penis and laser energy is used to vaporize the enlarged, obstructing prostate, to relieve the patient's urinary obstruction. The laser is also used to achieve appropriate hemostasis at the conclusion of vaporization. CPT code 52648 involves the prostatic urethra, which sits between the trigone of the bladder and the external urethral sphincter. Care must be taken throughout laser vaporization to prevent damage to the external sphincter, which can result in significant stress urinary incontinence, and prevent damage to the trigone of the bladder and the ureters. Care must also be taken to preserve the bladder neck as undermining the bladder neck can lead to significant complications including urinary extravasation. Following the

conclusion of the resection, care must be taken to ensure all tissue chips and blood clots are removed from the bladder or the catheter will become obstructed causing discomfort and potential bladder perforation. CPT code 52648 uses laser vaporization, which is a different technology than that used to perform CPT codes 52601 and 52597, however, ultimately the physician work is the same.

To support the survey 25th percentile work RVU of 10.05, the RUC compared the surveyed code to MPC codes 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time) and 57250 *Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy* (work RVU = 10.08, 60 minutes intra-service time and 211 minutes total time), noting that these services all require the same intra-service time of 60 minutes and similar physician work. The RUC noted that 52648 also requires the same intra-service time and similar physician work as codes 52597 and 52601 in this family of services and should be valued similarly.

For additional support, the RUC referenced MPC codes 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, 60 minutes intra-service time and 207 minutes total time) and 54437 *Repair of traumatic corporeal tear(s)* (work RVU = 11.50, 60 minutes intra-service time and 264 minutes total time) and determined that together these services appropriately bracket the surveyed code. The RUC determined that the survey 25th percentile work value of 10.05 appropriately places CPT code 52648 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 10.05 for CPT code 52648.**

52649 ***Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)***
The RUC reviewed the survey results from 30 urologists and determined maintaining the current work RVU of 14.56 appropriately accounts for the work required to perform this service. The RUC recommends 36 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238, 1-99214 and 1-99213, which totals 263 minutes. The pre-service positioning time was increased from the pre-service time package of 3 minutes to 10 minutes as indicated by the survey respondents to account for placing the patient in the dorsal-lithotomy position. The RUC noted some variability of the pre-service positioning and scrub/dress/wait time across this family of codes, however maintained the standard not to exceed times as indicated by the survey respondents.

This service is typically performed in the hospital setting. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit are typical. The RUC confirmed that the immediate post-service time of 40 minutes appropriately accounts for the immediate care of the patient (20 minutes) as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day. The survey respondents indicated that they perform a 99232 hospital visit and the RUC determined that the time should be captured in the immediate post-service time.

The random survey respondents indicated that two post-operative office visits are necessary following this procedure. The RUC agreed with the specialty societies that the two post-operative office visits levels are one 99213 and one 99214. During the 99214 post-operative office visit, issues of moderate complexity, including the management of chronic illness with progression or side effects of treatment are addressed. The urinary catheter is removed. Typically following catheter removal, patients will develop urinary incontinence as their external urethral sphincter becomes solely responsible for the maintenance of continence following the opening up of the prostate or bladder neck. Patients also will

typically have significant dysuria requiring significant counseling that this is a normal and expected outcome, secondary to the destruction or removal of prostate adenoma. The physician also discusses interventions of moderate risk, including prescription drug management. Prescription drug management is required to discuss and offer patients medications, including anticholinergic or beta-3 agonist medications to help limit post-operative symptoms within the 90-day global period. During the 99213 post-operative office visit, the physician will again discuss prescription drugs, change doses, and address side effects. However, the decision-making complexity is low with the management of a stable chronic illness.

The specialty societies indicated that the 30-minute decrease in intra-service time from when this was last surveyed in 2010 has likely occurred due to the diffusion of skilled surgeons performing this procedure nationally. Utilization of this code has increased substantially over the past ten years as increasing surgeon skill has allowed for the treatment of larger prostate glands with laser enucleation of the prostate. Studies have demonstrated improved voiding outcomes for patients with prostates greater than 100 grams undergoing laser enucleation compared to other bladder outlet procedure options. The increase in the typical prostate being treated with laser enucleation has led to a significant increase in procedural intensity.

CPT code 52649 involves laser enucleation to remove a majority of the patient's prostate adenoma from the inside out, as opposed to the other procedures in this family. For this service, the surgeon introduces a cystoscope with a laser bridge through the penis and makes an incision in the prostate adenoma using the laser. The laser is then used to continue this incision between the prostate capsule and the adenoma to the level of the prostatic capsule of the apex. The surgeon then carefully works towards the base of the prostate, enucleating the adenoma, and slowly dissecting it away from the capsule, pushing it into the bladder. Following the enucleation of the adenoma, a morcellator is introduced to the cystoscope, and the adenoma is morcellated within the bladder. Significant care must be taken throughout enucleation to prevent damage to the external sphincter, the bladder neck, and the ureters. Significant care must be taken during morcellation to prevent damage to the bladder from the morcellation process.

Care must also be taken to avoid perforating the capsule posteriorly and damaging the rectum, as the planes are quite challenging to see, especially with large prostate adenomas. Compared to the other procedures included in this family of codes, the concern for rectal injury caused by posterior perforation of the capsule is significantly higher, due to the inside-out approach that occurs with laser enucleation of the prostate. This approach does allow a greater amount of prostate tissue to be removed but significantly increases the difficulty and intensity required to perform CPT code 52649 compared to the other codes within this family. Therefore, the RUC believes the current value of 14.56 appropriately values this service using magnitude estimation compared to services within this family.

The RUC compared the surveyed code to the top key reference code 55821 *Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages* (work RVU = 15.18, 120 minutes intra-service time and 315 minutes total time) and noted that half of the survey respondents who chose this key reference service indicated that the surveyed code was more to much more intense and complex to perform overall. The RUC determined that these services require similar physician work to perform, thus, should be valued similarly.

For additional support, the RUC referenced MPC codes 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36, 90 minutes intra-service time and 248 minutes total time), which requires less intensity to perform than the surveyed code and 19303

Mastectomy, simple, complete (work RVU = 15.00, 90 minutes intra-service time and minutes 283 minutes total time) and determined that these services appropriately bracket the surveyed code. The RUC determined that the current work value of 14.56 appropriately places CPT code 52649 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 14.56 for CPT code 52649.**

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

New Technology/New Services List
CPT code 52597 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 overall work savings that should be redistributed back to the Medicare conversion factor.

Prostate Biopsy Services (Tab 8)
Michael Booker, MD (ACR), Seth Cohen, MD (AUA), Robert Kennedy, MD (SIR), Minhaj Khaja, MD (SIR), Jonathan Kiechle, MD (AUA), Andrew Moriarity, MD (ACR), Gerald Niedzwiecki, MD (OEIS), Cindy Yuan, 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 contained 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, it was clear that the survey respondents did not understand the coding structure. Specifically, the discussion revolved around the number of biopsies per code. 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 to 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 indicated that the long descriptors do not adequately describe these services. The survey intra-service time to take 20 biopsies was identical to the intra-service time to take two biopsies. For example, the specialty societies described that the survey response pre-time for 55710 *Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance biopsy, first*

targeted lesion is less than the survey pre-time for 55712 *Biopsy, prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion*, but 55710 is the more difficult procedure. Further, the intra-times are the same. This issue with the survey times also distorted the relative intensity between the family making it difficult to discern which service was the least to most difficult based on the number of biopsies per service. It seems as though, the minor difference between 55710 and 55712 is the language "ie, sextant" which implies a 12-core biopsy where two biopsies are taken from the six prostate sextant zones. The same issue exists for 55708 *Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance, first targeted lesion* which has less pre-time than 55711 *Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion* and identical intra-service time. In summary, the pre-times should be flipped – more time for 55710 and 55708 and less for 55712 and 55711. In addition to these concerns, RUC members also mentioned a point of confusion in the language between "biopsy" and "biopsies" in the codes' long descriptors. Further, the language "first targeted lesion" is not clear as that can often mean more than one biopsy is obtained. 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 to the CPT Editorial Panel for restructuring in the CPT 2027 cycle.

55705 ***Biopsy, prostate, any approach, nonimaging-guided***
The RUC reviewed the survey results from 50 urologists and recommends a work RVU of 1.93 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 15 minutes of pre-service evaluation time, 5 minutes positioning time, 5 minutes scrub/dress/wait time, 10 minutes intra-service time, 10 minutes immediate post-service time, and 45 minutes total time. The RUC is also recommending a global period change from a 010-day global to a 000-day global.

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 specialties 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 ultra-sound 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 key reference codes 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU = 1.73, 20 minutes intra-service, 59 minutes total time) and 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time). Of the survey respondents who chose CPT code 55876 as the key reference service, 44% indicated that the surveyed code was identical in intensity and complexity and 22% indicated that the surveyed code was more intense and complex when compared to the top key reference service code 55876. Moreover, 50% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 50% indicated that the surveyed code was more intense and complex when compared to the second key reference service code 55874. The complexity of the surveyed code, in a relatively short period of time, comes from the lack of imaging guidance. **The RUC recommends a work RVU of 1.93 for CPT code 55705.**

55707 ***Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant, ultrasound-localized discrete lesion[s])***
The RUC reviewed the survey results from 99 urologists and recommends a work RVU of 2.63 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 17 minutes of pre-service evaluation time, 5 minutes positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time, 8 minutes immediate post-service time, and 50 minutes total time.

This procedure includes a 12-core prostate biopsy performed transrectally with ultrasound guidance. The patients that 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, and 12 prostate biopsies are taken via prostate sextants which include any hyperechoic areas.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU = 1.73, 20 minutes intra-service, 59 minutes total time) and 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time). Of the survey respondents who chose CPT code 55876 as the key reference service, 44% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 50% indicated that the surveyed code was more intense and complex when compared to the top key reference service code 55876. Moreover, 60% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 40% indicated that the surveyed code was more intense and complex when compared to the second key reference service code 55874. **The RUC recommends a work RVU of 2.63 for CPT code 55707.**

55708 ***Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance, first targeted lesion***
The RUC reviewed the survey results from 80 urologists and recommends a work RVU of 3.39 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 20 minutes of pre-service evaluation time, 5 minutes positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, 10 minutes immediate post-service time, and 60 minutes total time.

Within the code family, this procedure is substantially more complex when compared to code 55707. 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 the appropriate fusion of the MRI image has taken place. The target lesion must be located on the ultrasound and typically, 2 biopsies will be taken out of the target lesion. Following the biopsy of the target lesion, complete sextant biopsies are obtained bringing the total number of typical biopsies to 14 for this procedure via transrectal approach.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 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 = 3.64, 45 minutes intra-service, 82 minutes total time) and 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time). Of the survey respondents who chose CPT code 19085 as the

key reference service, 30% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 70% indicated that the surveyed code was more intense and complex when compared to the top key reference service code 19085. Moreover, 40% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 60% indicated that the surveyed code was more intense and complex when compared to the second key reference service code 55874. **The RUC recommends a work RVU of 3.39 for CPT code 55708.**

55709 ***Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant, ultrasound-localized discrete lesion[s])***
The RUC reviewed the survey results from 60 urologists and recommends a work RVU of 3.23 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 20 minutes of pre-service evaluation time, 7 minutes positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, 10 minutes immediate post-service time, and 62 minutes total time.

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 that 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 key reference codes 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time) and 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU = 3.50, 30 minutes intra-service, 79 minutes total time). Of the survey respondents who chose CPT code 55874 as the key reference service, 25% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 69% indicated that the surveyed code was more intense and complex when compared to the top key reference service code 55874. Moreover, 40% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 40% indicated that the surveyed code was more intense and complex when compared to the second key reference service code 52214. **The RUC recommends a work RVU of 3.23 for CPT code 55709.**

55710 ***Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance biopsy, first targeted lesion***
The RUC reviewed the survey results from 58 urologists and recommends a work RVU of 3.81 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 20 minutes of pre-service evaluation time, 8 minutes positioning time, 5 minutes scrub/dress/wait time, 25 minutes intra-service time, 10 minutes immediate post-service time, and 68 minutes total time.

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 are 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 and the second highest complexity to perform within the code family.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time) and 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 45 minutes intra-service, 118 minutes total time). Of the survey respondents who chose CPT code 55874 as the key reference service, 21% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 72% indicated that the surveyed code was more intense and complex when compared to the first key reference service code 55874. Moreover, 17% of survey respondents indicated that the surveyed code was identical in intensity and complexity and 75% indicated that the surveyed code was more intense and complex when compared to the second key reference service code 52352. **The RUC recommends a work RVU of 3.81 for CPT code 55710.**

55711 ***Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion***
The RUC reviewed the survey results from 71 urologists and recommends a work RVU of 2.61 based on a direct crosswalk to code 47536 *Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation* (work RVU = 2.61, 20 minutes intra-service time, 51 minutes total time), which maintains relativity within the family for this code. The RUC recommends 22 minutes of pre-service evaluation time, 5 minutes positioning time, 5 minutes scrub/dress/wait time, 20 minutes intra-service time, 10 minutes immediate post-service time, and 62 minutes total time.

For this procedure, prior MRI imaging is fused with real-time ultrasound imaging to identify the target lesion. The ultrasound probe is placed transrectally. The target lesion is identified after the appropriate fusion and imaging is obtained and the targeted lesion is biopsied. This procedure requires two biopsies be obtained in a transrectal fashion compared to 12 biopsies obtained transrectally in other family codes.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time) and 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 = 3.64, 45 minutes intra-service, 82 minutes total time). The surveyed code is valued appropriately lower than the key reference service and other codes within this family given that only two biopsies are obtained during the procedure. **The RUC recommends a work RVU of 2.61 for CPT code 55711.**

55712 ***Biopsy, prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion***
The RUC reviewed the survey results from 55 urologists and recommends a work RVU of 3.10 based on a direct crosswalk to code 33993 *Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion* (work RVU = 3.10, 25 minutes intra-service time, and 70 minutes total time) which maintains relativity within the

family for this code. The RUC recommends 25 minutes of pre-service evaluation time, 8 minutes positioning time, 5 minutes scrub/dress/wait time, 25 minutes intra-service time, 10 minutes immediate post-service time, and 73 minutes total time.

For this procedure, a single lesion is biopsied fusing prior MRI imaging with real-time ultrasound imaging to identify the target lesion. Adequate imaging must be obtained, and appropriate fusion technology must be used to manually identify the target lesion. Typically, two biopsies are obtained through the target lesion. The difference with this service when compared to family code 55711 is that the procedure is performed via a transperineal approach instead of a transrectal approach, even though the typical number of biopsies obtained is identical. The transrectal approach is more challenging than the transrectal approach given the additional work to get to the target lesion with the image guidance and needle placement.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time) and 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 45 minutes intra-service, 118 minutes total time). The recommended work RVU is appropriately supported by the reference codes as the total time is above the top key reference code and below the second key reference code. **The RUC recommends a work RVU of 3.10 for CPT code 55712.**

55713 ***Biopsy, prostate, in-bore CT- or MRI-guided (ie, sextant), with biopsy of additional targeted lesion(s), first targeted lesion***

The RUC reviewed the survey results from 50 urologists, radiologists, and interventional radiologists and recommends a work RVU of 4.00 based on a direct crosswalk to code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU = 4.00, 25 minutes intra-service time, and 81 minutes total time), which maintains relativity within the family for this code. The RUC recommends 30 minutes of pre-service evaluation time, 10 minutes positioning time, 9 minutes scrub/dress/wait time, 25 minutes intra-service time, 13 minutes immediate post-service time, and 87 minutes total time. The pre-service period of this code requires more time than the other family codes given the prone positioning that occurs in an MRI bore, the MRI coil focus for the prostate, and the transrectal device positioning.

For this procedure, a biopsy of a single targeted lesion as well as a sextant biopsy of the targeted lesion with 14 biopsies typically obtained. This procedure includes the 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. Given that this service includes a single target lesion and the sextant biopsies, it is more challenging to perform and therefore should be valued higher than family code 55714.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 45 minutes intra-service, 118 minutes total time) and 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time). They surveyed code work RVU is appropriately bracketed by the key reference services given the lower intra-service and relative intensity to perform the service. **The RUC recommends a work RVU of 4.00 for CPT code 55713.**

55714 ***Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion***
The RUC reviewed the survey results from 53 urologists, radiologists, and interventional radiologists and recommends a work RVU of 3.62 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 30 minutes of pre-service evaluation time, 10 minutes positioning time, 9 minutes scrub/dress/wait time, 30 minutes intra-service time, 13 minutes immediate post-service time, and 92 minutes total time. The pre-service period of this code requires more time than the other family codes given the prone positioning that occurs in an MRI bore, the MRI coil focus for the prostate, and the transrectal device positioning.

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. Given that this service does not include the sextant biopsies, this code should be valued relatively lower than family code 55713.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 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 = 3.64, 45 minutes intra-service, 82 minutes total time) and 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 45 minutes intra-service, 118 minutes total time). The surveyed code is valued appropriately lower than the key reference services given the lower intra-service time. **The RUC recommends a work RVU of 3.62 for CPT code 55714.**

55715 ***Biopsy, prostate, each additional, MRI-ultrasound fusion or in-bore CT- or MRI-guided targeted lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 69 urologists, radiologists, and interventional radiologists and recommends a work RVU of 1.05 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 20 minutes of intra-service time and total time.

This add-on procedure is intended to be used regardless of biopsy approach when an additional target lesion is identified on the MRI beyond the first lesion. It is expected that multiple biopsies would typically be taken from additional lesions. The work related to the first lesion is included in the other codes within this family.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 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 = 1.82, 38 minutes intra-service, 43 minutes total time) and 10006 *Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU = 1.00, 15 minutes intra-service and total time). The work RVU is appropriately bracketed by the key reference services relative to the intra-service time required to perform this service. Further, code 10006 describes a similar service that uses image guidance to obtain biopsies of additional target lesions. **The RUC recommends a work RVU of 1.05 for CPT code 55715.**

55706 ***Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance***
The RUC reviewed the survey results from 54 urologists and recommends a work RVU of 4.27 based on a direct crosswalk to code 31254 *Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)* (work RVU = 4.27, 30 minutes intra-service, and 83 minutes total time) which maintains relativity within the family for this code. The RUC recommends 25 minutes of pre-service evaluation time, 8 minutes positioning time, 5 minutes scrub/dress/wait time, 30 minutes intra-service time, 11 minutes immediate post-service time, and 79 minutes total time. The RUC is also recommending a global period change from a 010-day global to a 000-day global.

For this procedure, saturation biopsy of the prostate using a template grid and transperineal approach to obtain biopsies every three to four millimeters throughout the prostate gland. This procedure is the most intense and complex to perform within the code family given that between 40-60 biopsies are typically obtained based on the overall size of the prostate. This procedure requires anesthesia for patients to tolerate the procedure and remain in one position throughout the procedure to obtain true saturation biopsy of the prostate.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75, 45 minutes intra-service, 118 minutes total time) and 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed* (work RVU = 3.03, 30 minutes intra-service, 70 minutes total time). The recommended work RVU is appropriately bracketed by the key reference services given the total time and intensity and complexity of obtaining between 40-60 biopsies.

For additional support, the RUC referenced code 43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices* (work RVU = 4.27, 30 minutes intra-service, and 81 minutes total time) which supports the recommended work RVU given the similar times and identical work RVU. **The RUC recommends a work RVU of 4.27 for CPT code 55706.**

76872 ***Ultrasound, transrectal***
The RUC reviewed the survey results from 87 urologists, radiologists, and interventional radiologists and recommends a work RVU of 0.67 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 6 minutes of pre-service evaluation time, 10 minutes intra-service time, 7 minutes immediate post-service time, and 23 minutes total time.

For this procedure, the physician fully evaluates the prostate for hypoechoic areas and prostatic calcifications. The prostate height and width are measured in the coronal plane and imaging is then changed to the sagittal plane and prostatic urethral length is measured to obtain appropriate prostatic volume measurements.

To support the recommended work RVU, the RUC compared the surveyed code to key reference codes 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = 0.67, 15 minutes intra-service, 27 minutes total time) and 76998 *Ultrasonic guidance, intraoperative* (work RVU = 0.91, 12 minutes intra-service, 22 minutes total time). The surveyed code work RVU is appropriately supported by the key reference services given the similar times. **The RUC recommends a work RVU of 0.67 for CPT code 76872.**

Practice Expense
The Practice Expense (PE) Subcommittee concurred that there is compelling evidence to support an increase over the aggregate current cost for clinical staff time, supplies and equipment for the code family based on changes in technique/technology resulting in missing required supplies and equipment.

The PE Subcommittee reviewed the direct practice expense inputs and made several modifications including removing CA026 *Clean surgical instrument package* for urology codes 55705, 55707-55712 as there are no surgical instrument packages in the supplies to clean. A change in clinical labor type from L051B *RN/ Diagnostic Medical Sonographer* to L037D *RN/LPN/MTA* was made for CPT code 76872 to align with the prostate biopsy code family, and also for 55713 and 55714 in CA010 and CA017. Additionally, the PE Subcommittee accepted five new supply items and one new equipment item for these services: *Transperineal ultrasound biopsy guide, Transrectal MRI-compatible -150mm fully automatic biopsy gun, Transrectal MRI-compatible needle guide, Disposable Prostate Core Biopsy Needle, Transrectal Ultrasound Biopsy Guide,* and *the UroNav system*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 55708, 55710, 55711, 55712, and 55715 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.

Referral to CPT Editorial Panel
The RUC recommended to refer this entire code family to the CPT Editorial Panel for restructuring in the CPT 2027 cycle. Specifically, to ensure that the long descriptor language and related guidelines appropriately 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 were few biopsies were obtained and services were 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 lack of clarity on the number of biopsies performed, per service. The societies informed the RUC that they have a Coding Change Application prepared for the February 2025 CPT Editorial Panel meeting for the CPT 2027 cycle.

RUC Database Flag
The RUC recommends that this entire code family be flagged for "Do Not Use to Validate Physician Work" in the RUC database.

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

<u>Cerebral Perfusion & CT Angiography – Head & Neck (Tab 9)</u>
Michael Booker, MD (ACR), Melissa Chen, MD (ASNR), Andrew Moriarity, MD (ACR), Jacob Ormsby, MD (ASNR), Cindy Yuan, MD (ACR)

In April 2022, the Relativity Assessment Workgroup (RAW) identified Category III code 0042T with 2020 Medicare utilization over 1,000. The RAW requested an action plan for September 2022. In September 2022, the specialty societies indicated, and the RUC agreed, that the code should be

referred to the CPT Editorial Panel. Category III code 0042T had increased utilization and now qualifies for Category I status.

In April 2022, the 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 contained at least one ZZZ global service were removed. In September 2022, the RAW recommended referring CPT codes 70496 and 70498 to the CPT Editorial Panel to create a code bundling solution.

In May 2024, the CPT Editorial Panel deleted the existing Category III code 0042T and created a bundled code for computed tomographic angiography (CTA), head and neck, as well as an add-on and a standalone code for computed tomographic (CT) cerebral perfusion analysis with and without concurrent CT or angiography of the same anatomy. Codes 70471-70473 were surveyed for the September 2024 RUC meeting, along with the existing standalone codes for CTA head (70496) and CTA neck (70498). Instructional and exclusionary parentheticals were also added throughout the code family.

70471 ***Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing***
The RUC reviewed the survey results from 65 radiologists and neuroradiologists and determined that the survey 25th percentile work RVU of 2.50 appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes of pre-service time, 30 minutes of intra-service time and 5 minutes of immediate post-service time as supported by the survey.

The RUC discussed the high intensity of the surveyed code which is typically an acute stroke situation. The specialties explained that CPT code 70471 is the most highly detailed of the CTA studies with many complex anatomic structures assessed including vasculature and soft tissue structures of the brain and neck. The cognitive load on the radiologist including the detailed spatial resolution of the images coupled with the time pressure and psychological stress associated with having to provide a result to the clinical team to triage the patient as quickly as possible to therapy, contributes to the significantly increased complexity of the surveyed code. CPT code 70471 is typically performed in the emergency room in patients with focal neurological deficits where there is clinical concern for large vessel occlusion.

The RUC compared CPT code 70471 to the top key reference service code 74712 *Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation* (work RVU = 3.00, 60 minutes intra-service time and 90 minutes total time) and noted that the intra-service time is twice that of the surveyed code justifying the higher value. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the intensity of the surveyed code. The reference code is one of the lengthier magnetic resonance studies with spatial resolution, less than a CTA. The work involved in magnetic resonance imaging (MRI) is related to the assessment of the different sequences acquired where there may be motion in between sequences of the fetus. The implications of the findings on the MRI are typically not associated with time-sensitive or intervenable conditions. Those intervenable conditions are not as time-sensitive as the CT angiogram head and neck. The MRI findings are often used to help counsel patients and families when any abnormalities are detected, while 70471 is a potentially life-saving service.

The RUC also referenced the second key reference MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast*

material(s), including noncontrast images, if performed, and image postprocessing (work RVU = 2.40, 39 minutes intra-service time and 57 minutes total time) and again noted that the intensity of the surveyed code offsets the higher intra-service time for the key reference service. Over 90% of the survey respondents who selected the second key reference service rated 70471 as more intense and complex, justifying the higher work value for the surveyed code. The reference code is typically performed in the outpatient setting in patients with a known history of atherosclerotic disease, while 70471 is typically performed in the emergency department and is much more intense given that the impact of the exam will determine if the patient is a candidate for thrombolytic therapy or thrombectomy, which could significantly change patient's morbidity and mortality.

For additional support, the RUC compared CPT code 70471 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 = 2.29, 25 minutes intra-service time and 35 minutes total time) and noted that the comparator code has less intra-service and total time than 70471, thus has a lower work RVU. The RUC further compared the surveyed code to CPT code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time) and noted that, although the times are similar, the CT abdomen is an outpatient study and therefore not as intense as 70471, justifying the higher value for the surveyed code.

The RUC concluded that CPT code 70471 should be valued at the 25th percentile work RVU as supported by the survey and appropriately bracketed by the key reference service codes. **The RUC recommends a work RVU of 2.50 for CPT code 70471.**

70472 ***Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 63 radiologists and neuroradiologists and determined that a direct work RVU crosswalk to CPT code 58110 *Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)* (work RVU = 0.77, 12 minutes intra-service and total time) accurately reflects the physician work necessary for this new add-on service. CPT code 70472 requires the assessment of multiple color maps that are generated while correlating with anatomic imaging to distinguish salvageable ischemic brain tissue from infarcted brain tissue. The RUC recommends 12 minutes intra-service and total time.

The RUC compared CPT code 70472 to the top key reference service code 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU = 0.83, 10 minutes intra-service and total time) and noted that the intra-service time is less than the surveyed code but the service is more intense, justifying the higher value for the reference code. The RUC also referenced the second key reference service code 19288 *Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)* (work RVU = 1.28, 30 minutes intra-service time and 35 minutes total time) and noted that the reference service requires significantly more time than the surveyed code and is therefore appropriately valued higher. CPT code 19288 describes placement of a localization device using MRI which has more intra-service and total time than the surveyed code, but it requires some less intense time of imaging the patient during the procedure to ensure appropriate trajectory and placement of the device.

For additional support, the RUC compared CPT code 70472 to MPC code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service and total time) and noted that the non-radiology comparator code has more intra-service and total time than the surveyed code justifying the higher value.

The RUC concluded that CPT code 70472 should be valued based on a direct work RVU crosswalk to CPT code 58110 which falls below the survey 25th percentile. **The RUC recommends a work RVU of 0.77 for CPT code 70472.**

70473 *Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy*
The RUC reviewed the survey results from 57 radiologists and neuroradiologists and determined that the survey median work RVU of 1.00 appropriately accounts for the physician work involved in this service. CPT code 70473 requires the assessment of multiple color maps and synthesis of that information in conjunction with anatomic brain imaging to differentiate ischemic, salvageable brain tissue from infarcted brain tissue. The RUC recommends 5 minutes of pre-service time, 12 minutes of intra-service time and 5 minutes of immediate post-service time as supported by the survey.

The RUC compared CPT code 70473 to the top key reference service code 70486 *Computed tomography, maxillofacial area; without contrast material* (work RVU = 0.85, 10 minutes intra-service time and 16 minutes total time) and noted that the reference service requires evaluation of the soft tissues and bones of the face, but assessment is somewhat limited given the lack of contrast. The work in 70473 requires slightly more time because the study involves the synthesis of multiple points of information for decision-making compared to the work of 70486, justifying a higher value for the surveyed code.

The RUC also referenced the second key reference service code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (work RVU = 1.78, 20 minutes intra-service time and 32 minutes total time) and noted that the reference service involves similar work to 70473 in the evaluation of multiple sequences of the same anatomic region to assess for abnormalities. However, the reference service has more images and therefore more intra service time, thus justifying a higher value for the reference code.

For additional support, the RUC noted that CPT code 70473 is appropriately bracketed between 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 = 0.90, 15 minutes intra-service time and 22 minutes total time) and 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU = 1.28, 15 minutes intra-service time and 25 minutes total time).

The RUC concluded that CPT code 70473 should be valued at the median work RVU as supported by the survey and appropriately bracketed by both the key reference service codes and MPC codes. **The RUC recommends a work RVU of 1.00 for CPT code 70473.**

70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing*
The RUC reviewed the survey results from 63 radiologists and neuroradiologists and determined that the current work RVU of 1.75 appropriately accounts for the physician work involved in this service and falls slightly below the survey 25th percentile. The RUC recommends 5 minutes of pre-service

time, 18 minutes of intra-service time and 5 minutes of immediate post-service time as supported by the survey.

The RUC discussed the high intensity of the surveyed code and the complexity of the patient population. The specialties explained that the patients in whom this service would be performed in isolation will likely be those patients who have had previous interventions either for aneurysm, occlusion, or stenosis and who are presenting with neurologic symptoms. In the last decade, the capabilities of neurointerventionalists have vastly expanded with new devices that can treat more distal diseases including clots in the M3 segment of the middle cerebral artery, as well as for therapy of smaller aneurysms. Because of this, the radiologist assesses more distal disease sites more carefully in smaller structures relative to when this was originally surveyed.

Furthermore, the work associated with 70496 is more intense than the prior survey because multiple studies have now shown the proven benefit of mechanical thrombectomy, therefore making CTA head and neck a critical component of stroke care where every minute counts to preserve brain function, leading to increased psychological stress when interpreting these studies. Since this code was last valued, additional reconstructed images, such as Maximum Intensity Projections (MIPS), are now in widespread use. Although there are more images to review, these MIP reconstructions allow radiologists to recognize focal stenosis or imaging findings of vasculitis more easily. This contributes to some of the decreased time spent reviewing images relative to the last time this was valued. The RUC acknowledged the two-minute decrease in time and also the increase in the number of images and the capabilities of the interventions. It was noted that due to the code bundling, the surveyed code will now be reported on a complex patient with prior interventions.

The RUC compared CPT code 70496 to the top key reference service code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time) and noted that the intra-service time is much higher than the surveyed code justifying the higher value. The reference code requires an assessment of the vasculature of the abdomen and pelvis and is associated with more images given the larger anatomic region covered compared to the surveyed code. However, the RUC also noted that the intensity of the surveyed code offsets the higher intra-service time for the key reference service. CPT code 70496 is considered more intense, with 88% of survey respondents who selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code, which supports maintaining the current value.

The RUC also referenced the second key reference code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.82, 25 minutes intra-service time and 35 minutes total time) and again noted that the intensity of the surveyed code offsets the higher intra-service time for the key reference service. The reference code is the assessment of the vasculature in the chest and covers a larger anatomic region than the surveyed code. However, over 90% of the survey respondents who selected the second key reference service rated 70496 as more intense and complex, justifying maintaining the work value for the surveyed code. CPT code 70496 is more intense than both reference codes given the potential devastating neurologic complications that could occur if a finding is missed.

For additional support, the RUC noted that CPT code 70496 is appropriately bracketed between MPC codes 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time) and 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 = 2.01, 30 minutes intra-

service time and 40 minutes total time). Both MPC comparison codes are associated with less intense work than the CT angiography head code. Accounting for the survey times and intensity differences, the recommended current work RVU is appropriately bracketed between codes 74176 and 74178.

The RUC concluded that the existing value of CPT code 70496, which falls below the survey 25th percentile work RVU, should be maintained and is appropriately bracketed by the comparator codes. **The RUC recommends a work RVU of 1.75 for CPT code 70496.**

70498 ***Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing***
The RUC reviewed the survey results from 62 radiologists and neuroradiologists and determined that the current work RVU of 1.75 appropriately accounts for the physician work involved in this service and represents the survey 25th percentile. The RUC recommends 5 minutes of pre-service time, 18 minutes of intra-service time and 5 minutes of immediate post-service time as supported by the survey.

The RUC discussed the high intensity of the surveyed code and the complexity of the patient population. The expected typical patient for 70498 is a patient who has had prior intervention, likely prior stenosis in a carotid vessel, who is presenting with neurologic symptoms. Given that these patients had an identified abnormality or prior intervention, this patient population is more complex than when it was previously surveyed.

Furthermore, as with 70496, the work associated with 70498 is more intense than prior survey because multiple studies have now shown the proven benefit of mechanical thrombectomy, therefore making CTA head and neck a critical component of stroke care where every minute counts to preserve brain function, leading to increased psychological stress when interpreting these studies.

Since this code was last valued, additional reconstructed images, such as Maximum Intensity Projections (MIPS), are now standard use across practice. Although there are more images to review, these newly reconstructed images save some time for the radiologist to identify specific conditions such as vasculitis or dissection. Previously, this would have required more careful scrutiny of the source axial images and may not have been picked up previously.

The RUC compared CPT code 70498 to the top key reference service code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.82, 25 minutes intra-service time and 35 minutes total time) and noted that the higher intra-service time for the key reference service is offset by the intensity of the surveyed code. The reference code is the assessment of the vasculature in the chest and covers a larger anatomic region than the surveyed code. However, over three-fourths of the survey respondents who selected the top key reference service rated 70498 as more intense and complex, justifying maintaining the work value for the surveyed code.

The RUC also referenced the second key reference code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.20, 30 minutes intra-service time and 40 minutes total time) and noted that the intra-service time is much higher than the surveyed code justifying the higher value. The reference code requires an assessment of the vasculature of the abdomen and pelvis and is associated with more images given the larger anatomic region covered compared to the surveyed code. However, the RUC also noted that the higher intra-service time for the key reference service is offset by the intensity of the surveyed code. CPT code 70498 is considered more intense, with nearly 80%

of survey respondents who selected the reference code indicating that the survey code had more overall intensity/complexity relative to the key reference code, which supports maintaining the current value. CPT code 70498 is more intense than both reference codes given the potential devastating neurologic complications that could occur if a finding is missed.

For additional support, the RUC noted that CPT code 70498 is appropriately bracketed between MPC codes 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74, 22 minutes intra-service time and 32 minutes total time) and 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 = 2.01, 30 minutes intra-service time and 40 minutes total time). Both MPC comparison codes are associated with less intense work than the CT angiography neck code. Accounting for the survey times and intensity differences, the recommended current work RVU is appropriately bracketed between codes 74176 and 74178.

The RUC concluded that the existing value of CPT code 70498 represents the survey 25th percentile and should be maintained as supported by the survey. **The RUC recommends a work RVU of 1.75 for CPT code 70498.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made one modification to CPT code 70472 to remove minutes from CA006 *Confirm availability of prior images/studies* and CA007 *Review patient clinical extant information and questionnaire* to eliminate duplication as 70472 is an add-on code. The PE Subcommittee agreed with the specialty recommendation to change the clinical staff type for CPT codes 70496 and 70498 from L041B *radiologic technologist* to L046A *CT Technologist*. **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.

<u>Colon Motility Services (Tab 10)</u>
Stephen Sentovich, MD (ASCRS), Bruce Cameron, MD (ACG), Patricia Garcia, MD (AGA), Seth A. Gross, MD (ASGE), Brad Kuo, MD (AGA), Shivan Mehta, MD (AGA), Kelly Tyler, MD (ASCRS)

In April 2023, the Relativity Assessment Workgroup (RAW) identified codes 91120 and 91122 as reported together 75% or more based on 2021 Medicare claims data. The RUC noted that these services are reported together 95% of the time and the specialty societies should develop a code bundling solution via the CPT Editorial Panel. In May 2024, the CPT Editorial Panel added two codes to report rectal sensation testing and anal manometry with rectal sensation and balloon expulsion test, respectively. The two existing Category I codes 91120 and 91122 were deleted. The two new codes were surveyed for the September 2024 RUC meeting.

Compelling Evidence
The RUC agreed with the specialty societies that there is compelling evidence to support a change in physician work for the code family based on a documented change in technique/technology. When reviewing this family of services, the RUC considered that for 91124 there is documentation in

clinical literature of an increase in barostat procedure time consistent with current RUC survey data. In the last 20 years since this code was created, there have been substantial updates to the protocols used for rectal sensation, tone and compliance testing (e.g., barostat) resulting in changes to physician time. Clinical literature references indicate that it takes 60 minutes of active physician time to perform barostat testing. In addition, in reviewing 91125, the RUC determined that there is documentation in the clinical literature of a change in anorectal manometry technology and technique from conventional water-perfusion manometry to high-resolution solid-state manometry. There have been substantial advances in anorectal manometry technology and technique in the last 20 years. In 1995, the standard or "conventional" manometry was performed using non-high resolution, water-perfused catheters. In 2007, high-resolution manometry was introduced in which solid-state catheters could record and display simultaneous and dynamic information from the whole anal canal and distal rectum. Improved spatial resolution and signal processing allowed for data to be displayed as spatiotemporal color-contour pressure topography plots rather than overlapping line tracings improving diagnostic yield and accuracy. The use of high-resolution anorectal manometry is now typical.

The RUC concurred that there is compelling evidence that the physician work for these services has changed due to change in physician technique/technology.

91124 ***Rectal sensation, tone, and compliance study (eg, barostat)***
The RUC reviewed the survey results from 68 gastroenterologists and colon and rectal surgeons and determined that the survey median work RVU of 3.05 appropriately accounts for the physician work involved in this infrequent service. The RUC recommends 10 minutes of pre-service time, 60 minutes of intra-service time and 15 minutes of immediate post-service time as supported by the survey. While the survey median pre-service evaluation time was 12 minutes, the specialties recommended 10 minutes for consistency with similar XXX global procedures. The specialties also noted the procedure requires more pre- and post-time than the related capsule codes in which patients swallow a capsule and then return a recording device several hours later. The 60 minutes intra-service time is comprised of active, collaborative, physical technical work that takes 50 minutes of combined physician and clinical staff time. There is an additional 40 minutes of clinical staff only time, during which patients are monitored for two 20 minute adaptation and equilibration periods, as well as an additional 10 minutes of physician-only time for cognitive interpretation.

The RUC compared CPT code 91124 to the top key reference service 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 88 minutes total time) and noted that the reference service involves similar time and intensity, justifying the median work value for the surveyed code. The RUC also referenced the second key reference service code 91112 *Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report* (work RVU = 2.10, 40 minutes intra-service time and 60 minutes total time) and noted that the reference service requires much less intra-service time and total time, thus the surveyed code is appropriately valued higher.

For additional support, the RUC noted that CPT code 91124 is appropriately bracketed between MPC codes 99205 and 99204 *Office or other outpatient visit for the evaluation and management of a new 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, 45 minutes must be met or exceeded.* (work RVU = 2.60 and 60 minutes total time). It was further noted

that at the median value, the surveyed code fits centrally in comparison to XXX global codes with similar intra-service time and total time.

The RUC concluded that CPT code 91124 should be valued at the median work RVU as supported by the survey and appropriately bracketed by both the key reference service codes and MPC codes. **The RUC recommends a work RVU of 3.05 for CPT code 91124.**

91125 ***Anorectal manometry, with rectal sensation and rectal balloon expulsion test, when performed***

The RUC reviewed the survey results from 76 gastroenterologists and colon and rectal surgeons and determined that the survey median work RVU of 2.70 appropriately accounts for the physician work involved in this service. CPT code 91125 is a new code for anorectal manometry, with rectal sensation and rectal balloon expulsion testing, and represents the bundling solution for deleted CPT codes 91120 *Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)* and 91122 *Anorectal manometry*.

The RUC recommends 10 minutes of pre-service time, 45 minutes of intra-service time and 15 minutes of immediate post-service time as supported by the survey. The intra-service time is comprised of 30 minutes to perform all the maneuvers of the digital rectal examination with the nurse (RN/LPN/MTA) present and 15 minutes of cognitive physician work to review and interpret the multiple components, images and quantitative measurements. CPT code 91125 has a physical technical component involving the insertion and manipulation of an anorectal catheter, not just a cognitive interpretation component like the related capsule codes (91112, 91113). Because of this, a more extensive review of the medical record and discussion with the patient is required to ensure that the maneuvers and protocols performed are safe and tailored to their individual history. More specific positioning is also required in terms of post time where patients swallow a capsule, and the data is uploaded hours later for physician interpretation and asynchronous communication with patients.

The RUC discussed the intensity of the surveyed code and agreed that the median value places it in the correct rank order with the related procedures that include: the smart pill, barostat, colon capsule, anorectal manometry, code capsule endoscopy, and the 99205 office visit.

The RUC compared CPT code 91125 to the top key reference service code 91112 *Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report* (work RVU = 2.10, 40 minutes intra-service time and 60 minutes total time) and noted that the reference service requires less intra-service and total time and is less intense than the surveyed code. CPT code 91125 is considered more intense, with 95% of survey respondents who selected the reference code indicating that the surveyed code has more overall intensity/ complexity relative to the key reference code. The work related to 91112 is less intense and complex because it involves a swallowed capsule that passively captures transit and pressure measurements, while 91125 requires active participation from the physician to elicit and measure response to various maneuvers. The RUC also referenced the second key reference service code 91113 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report* (work RVU = 2.41, 45 minutes intra-service time and 60 minutes total time) and noted that the reference service involves similar work to 91125 but is less intense with less total time, justifying a higher work value for the surveyed code.

For additional support, the RUC noted that CPT code 91125 is appropriately bracketed between MPC codes 99204 *Office or other outpatient visit for the evaluation and management of a new 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, 45 minutes must be met or exceeded.* (work RVU = 2.60, 60 minutes total time) and 99215 *Office or other*

outpatient visit for the evaluation and management of an established 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, 40 minutes must be met or exceeded. (work RVU = 2.80, 70 minutes total time).

The RUC concluded that CPT code 91125 should be valued at the median work RVU as supported by the survey and further, that the intensity at the median maintains relativity amongst the GI test codes. **The RUC recommends a work RVU of 2.70 for CPT code 91125.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made one modification to reallocate 3 minutes from the post-service activity CA040 *Perform additional positioning of patient* to the pre-service (of the service period) activity CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient*. The specialties explained that 30 minutes was requested for CA024 *Clean room/equipment by clinical staff* rather than CA025 *Clean scope* because a catheter is utilized as the "equipment," not a scope, although the work is similar. The PE Subcommittee accepted two new supply items for use in CPT codes 91124 and 91125, *Anorectal expulsion balloon* and S*heath, catheter.* The specialty societies explained the submission of three updated invoices for the separate components of EQ070 *barostat system, with hardware & software.* **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Immunization Counseling (Tab 11)
Suzanne Berman, MD (AAP), Bradley Fox, MD (AAFP), Charles Hamori, MD (ACP), Steven E. Krug, MD (AAP), Paul Martin, DO (AOA)

In May 2024, the CPT Editorial Panel created three new time-based codes to report vaccine counseling performed where a vaccine is not administered. These services were surveyed and reviewed at the September 2024 RUC meeting.

Vaccine counseling services performed by physicians and other QHPs is critical to increasing vaccination rates and combatting hesitancy. These services entail listening to patient concerns, answering questions, and building trust; selecting counseling strategies and conveying information in a manner specific to each patient's concerns, cultural beliefs, and literacy level; providing patients with appropriate resources; and planning with patients to immunize in the future or engage in alternative preventive strategies. These activities are above and beyond those captured in an Evaluation and Management (E/M) or preventive visit.

90482 ***Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; 3 minutes up to 10 minutes***
The RUC reviewed the survey results from 148 physicians and determined the survey 25th percentile work RVU of 0.24 appropriately accounts for the work required to perform this service. The RUC recommends 6 minutes of intra-service and total time. There is no pre-service or post-service time as this service is typically reported with an E/M office visit or preventive medicine visit.

The RUC compared the surveyed code to the top two key reference services CPT code 99406 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (work RVU = 0.24 and 7 minutes intra-service and total time) and 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid*

administered (work RVU = 0.24 and 7 minutes intra-service and total time). The RUC agreed that these services require the same physician work and similar physician time to perform, thus, should be valued the same. The RUC agreed that the intensity and risk associated with counseling to possibly administer a life-saving vaccine or provide herd immunity in a given community is greater for this service than the key reference services.

For additional support, the RUC referenced MPC codes 99281 *Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional* (work RVW = 0.25 and 10 minutes intra-service time and total time), 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVW = 0.28, 7 minutes intra-service time and 13 minutes total time) and 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVW = 0.30, 7 minutes intra-service time and 10 minutes total time). The RUC determined that the survey 25th percentile work value of 0.24 appropriately places CPT code 90482 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.24 for CPT code 90482.**

90483 *Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; greater than 10 minutes up to 20 minutes*

The RUC reviewed the survey results from 127 physicians and determined the survey 25th percentile work RVU of 0.50 appropriately accounts for the work required to perform this service. The RUC recommends 13 minutes of intra-service and total time. There is no pre-service or post-service time as this service is typically reported with an E/M office visit or preventive medicine visit.

The specialty societies stated that immunization counseling codes 90483 and 90484 will most often be reported in visits where the physician or QHP must counsel the patient on multiple vaccines, address patient concerns, and develop future immunization or preventive strategies for each of these vaccines. The typical patient has done exploration on the internet and comes to the visit with numerous questions and concerns about some, if not all, of the immunizations in question. The need to tailor counseling strategies to each patient, their cultural backgrounds, and the unique concerns they may have about each immunization contributes to the higher levels of intensity, complexity, and psychological stress identified by respondents.

The RUC compared the surveyed code to the top key reference service CPT code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50 and 15 minutes intra-service and total time) and determined that these services require the same physician work and a similar amount of physician time to perform, thus should be valued the same. The RUC compared the surveyed code to the second top key reference service, 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded* (work RVU = 0.70 and 16 minutes total time). The RUC agreed that the surveyed code requires less physician work, slightly less physician time and is slightly less intense to perform than 99212, thus should be valued lower.

For comparison, the RUC looked at a scenario if a physician provided administration of an immunization with counseling, reporting CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health*

care professional; first or only component of each vaccine or toxoid administered (work RVU = 0.24 and 7 minutes total time) and also provided a second immunization, CPT code 90461 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)* (work RVU = 0.18 and 5 minutes total time), the result is 12 minutes total time and a work RVU of 0.42. The RUC determined this scenario was an appropriate comparison because CPT code 90483 involves the physician/QHP having a more in-depth and difficult discussion with the patient, requiring more time and intensity, providing 13 minutes of counseling as indicated by the 127 physician survey respondents.

For additional support, the RUC referenced MPC codes 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVW = 0.50 and 7 minutes intra-service time and 17 minutes total time) and 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVW = 0.50, 10 minutes intra-service time and 13 minutes total time). The RUC determined that the survey 25th percentile work value of 0.50 appropriately places CPT code 90483 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.50 for CPT code 90483.**

90484 *Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; greater than 20 minutes*

The RUC reviewed the survey results from 139 physicians and determined the survey 25th percentile work RVU of 0.75 appropriately accounts for the work required to perform this service. The RUC recommends 22 minutes of intra-service and total time. There is no pre-service or post-service time as this service is typically reported with an E/M office visit or preventive medicine visit.

The specialty societies stated that immunization counseling codes 90483 and 90484 will most often be reported in visits where the physician or QHP must counsel the patient on multiple vaccines, address patient concerns, and develop future immunization or preventive strategies for each of these vaccines. The typical patient has done exploration on the internet and comes to the visit with numerous questions and concerns about some if not all of the immunizations in question. The need to tailor counseling strategies to each patient, their cultural backgrounds, and the unique concerns they may have about each immunization contributes to the higher levels of intensity, complexity, and psychological stress identified by respondents.

The RUC compared the surveyed code to the top key reference service CPT code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded* (work RVU = 1.30 and 30 minutes total time) and determined that CPT code 90484 requires less physician work and time to perform, thus should be valued lower. The RUC compared the surveyed code to the second top key reference service, 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded* (work RVU = 0.70 and 16 minutes total time). The RUC agreed that the surveyed code requires slightly more physician work and time to perform, thus, should be valued higher than 99212.

For comparison to 22 minutes of immunization administration *with counseling*, a physician would need to report CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (work RVU = 0.24 and 7 minutes total time), plus 3 additional immunizations, CPT code 90461 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)* (work RVU = 0.18 and 5 minutes total time), totaling 0.78 work RVUs. The RUC determined the survey 25th percentile work RVU of 0.75 and total time of 22 minutes for 90484 immunization counseling demonstrates the correct relativity compared to immunization administration with counseling services.

For additional support, the RUC referenced MPC codes 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVW = 0.75 and 20 minutes intra-service time and 26 minutes total time), 95972 *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 complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional* (work RVW = 0.80, 23 minutes intra-service time and 36 minutes total time), and 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84, 10 minutes intra-service time and 22 minutes total time). The RUC determined that the survey 25th percentile work value of 0.75 appropriately places CPT code 90484 relative to other services in the MFS based on time, work, intensity, and complexity. **The RUC recommends a work RVU of 0.75 for CPT code 90484.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made one modification to reduce the time for documentation for clinical activity CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)* from 3 to 2 minutes for codes 90482-90484 to eliminate any duplication between CA034 and CA008 *Perform regulatory mandated quality assurance activity (pre-service)*. The PE Subcommittee also discussed supply item SK012 *CDC information sheets* and agreed that the quantity recommended for each code is consistent with the corresponding vignette. Specifically, two vaccines are mentioned in the vignette for both 90482 and 90483, so two CDC information sheets are recommended for each code. For code 90484, the vignette references a two-month, routine well-child visit, such visits typically involve 5-7 immunizations, so six CDC information sheets are recommended. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

G-Code Request for Deletion
The RUC requests that CMS delete codes G0310-G0313, as there is no longer a need for these G-codes with the creation of new CPT codes 90482-90484.

XI. Research Subcommittee (Tab 12)

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

- **Minutes, May 29th Research Subcommittee Specialty Requests Meeting Report Review**

The Research Subcommittee report from the May 29th conference call included in Tab 12 of the September 2024 agenda materials was approved without modification.

- **Discussion – RUC Use of Crosswalks**

  At the April 2024 RUC meeting, a RUC member inquired about the number of times a crosswalk code did not have the same global period as the surveyed code (as that was the case for one code at the April 2024 meeting). The RUC referred this issue to the Research Subcommittee for review at the September 2024 meeting.

  In September 2024, AMA staff provided the Subcommittee with an analysis of the RUC recommendations for 495 codes from the CPT 2021-2025 RUC cycles which also underwent a RUC survey. 82 (17%) of these recommendations were based on a crosswalk. When the RUC recommendation was based on a crosswalk code, the RUC always recommended an identical work RVU. In addition, both services had identical global period assignments 100% of the time. For a significant number of codes, the RUC recommended time was within 10% of the time for the crosswalk code (87% intra-time and 51% total-time). Every crosswalk code selected had been reviewed by the RUC (100%).

  The Chair noted that at the September 2023 RUC meeting, the RUC approved language regarding crosswalks including that they should have the same global period, be recently reviewed, have similar intra-service time and total time, be clinically similar to the surveyed code, and not be flagged as "Do Not Use to Validate Physician Work" in the RUC database. However, these guidelines are included in the instructions for developing work RVU recommendations document which is for specialty societies developing recommendations and do not limit the RUC or facilitation committees specifically as they review RVU recommendations for a code or code family.

  After review of the analysis prepared by AMA staff, the Subcommittee concluded that the RUC has an excellent track record over the past five years of selecting crosswalks that are consistent with the guidelines provided to the specialty societies and no defined requirements for the RUC are indicated. The Subcommittee noted that there were no instances of different global periods for the five years prior to the April 2024 meeting. **The Research Subcommittee agreed that no changes were warranted for the RUC's crosswalk methodology.**

- **RUC Intensity and Complexity Survey Questions**

  During the April 2024 RUC New Business discussion, a RUC member inquired about the intensity/complexity survey questions and the use of "identical" as the midpoint of the five-point comparison scale included in the standard RUC survey templates or if the midpoint should instead state "similar" intensity/complexity compared to the key reference services. The inquiry was based on a concern that survey respondents may be reluctant to select the term "identical" as this implies an exactness. The RUC referred this item for consideration by the Research Subcommittee at the September 2024 meeting. In September 2024, several Subcommittee members expressed support for switching away from "identical", which many concurred was too exact. Many members expressed support for the term "same". One member suggested "nearly the same". Also, the Subcommittee discussed changing the intensity/complexity question to remove the word "directly" from the following sentence: "Using your expertise, consider how each

survey code compares directly to the corresponding reference code." Several Subcommittee members expressed support for this change as well.

The Research Subcommittee determined that the members and staff needed to consider the change, seeking out additional information about the impact of the terms "same" and "identical" in survey research. The Subcommittee did not make a final decision on these changes and will continue this discussion at a future meeting.

- **Proposed Custom RUC Survey for Lower Extremity Revascularization (LER) Services**

  At the September 2024 CPT Editorial Panel meeting, the Panel created 46 new CPT codes to describe Lower Extremity Revascularization (LER) services and deleted the 16 existing lower extremity revascularization codes. The surveying societies submitted a proposal for surveying these codes for the January 2025 meeting using a custom survey instrument.

  Prior to the meeting, the surveying specialty societies submitted a proposal to conduct a standard RUC survey of anchor codes for the family and then conduct an abbreviated survey for the other codes in the same template. Each physician in the sample would receive a standard RUC survey for the 10 anchor codes and one abbreviated survey. The specialty societies will break up their samples to evenly distribute the abbreviated surveys. The presenters noted that the intent of their proposal is to avoid survey fatigue and to maximize the number of survey responses for each code.

  Overall, Subcommittee members were supportive of the request for a combined full and abbreviated survey. Several Subcommittee members expressed concern with the initial proposal to divide respondents into three groupings with a preference for two groupings, and also expressed concerns with the group of anchor survey codes not having an angioplasty only service. Subcommittee members requested the societies consider switching the abbreviated survey groupings to two groups instead of three. Also, the Subcommittee requested that the societies reconsider the representation of anchor codes that would receive a full RUC survey. The Chair suggested the societies consider adding a question on the survey to assess the typical number of blockages/stenoses typical for the femoral/ popliteal stent and/or atherectomy/stent codes.

  In order to provide additional time for the surveying societies, the Research Subcommittee reconvened the next morning. The societies provided an updated proposal with 11 anchor survey codes which represented every territory in the family, straightforward procedures, complex procedures, angioplasty only procedures, stent placement procedures, atherectomy procedures and add-on procedures. Also, the societies provided two groupings of abbreviated survey codes instead of three. Finally, the societies provided a list of which comparator codes would be used for the intensity/complexity question for each abbreviated survey code (included in the September 2024 handouts at the meeting folder). **The Research Subcommittee approved the custom survey instrument and methodology as described in the tables included in the September 2024 Research Subcommittee meeting report.**

The RUC approved the Research Subcommittee Report.

XII. Practice Expense Subcommittee (Tab 13)

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

High-Cost Supplies
The PE Subcommittee expressed its continued concern with the issue of high-cost supplies and the need to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology, noting that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500.

For the September 2024 meeting, the discussion and analysis of the high-cost supplies issue was referred to the Relativity Assessment Workgroup (RAW) meeting (Tab 14) to determine whether codes with high-cost disposable supplies should be flagged for PE re-review through development of a High-Cost Disposable Supplies Screen.

The RAW examined the data and emphasized that for at least 20 years, **the RUC has continually called on CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The RAW requested formation of a joint CPT and RUC workgroup to address the issue of high-cost disposable supplies.**

Radiology-specific Clinical Activities
The PE Subcommittee continued its consideration of the use of Clinical Activity (CA) code CA014 *Confirm order, protocol exam.* In April, the Subcommittee had determined that the CA014 minutes could be allocated in non-imaging codes. **The PE Subcommittee determined updates to the Benchmarks for CA014 to read as follows:**

7. **Confirm order, protocol exam, standardized to 1 minute.<u>, e.g., selecting which imaging sequences or contrast phases to perform in CT and MRI. 0 minutes for verifying the correct patient and procedure/ medication (aka the "time out").</u>**

The PE Subcommittee further determined that for the six codes (CA006, CA007, CA014, CA030, CA031, and CA032) which state "For use in imaging services," the statement should be removed such that the specialties can justify the 1 or 2 minute standard for each procedure as needed. **The PE Subcommittee determined updates to CA006, CA007, CA014, CA030, CA031, and CA032 to simply state: "2 minute standard" or "1 minute standard".**

In addition, the Subcommittee discussed the 2 minute standard for CA006 *Confirm availability of prior images/studies.* This standard was developed in 2014, and members acknowledged that the review of images using PACS is much quicker, yet the number of images has greatly increased. Thus, two minutes was still found to be appropriate for confirming the availability of prior images/studies.

Equipment Inputs Less than $500
The RUC discussed that there are eleven equipment items in the current equipment database that are less than the $500 threshold that CMS has established for equipment. This could be an artifact of the medical supply and equipment repricing project in CY2019-2022. When the items were repriced, they should have been removed from the equipment listing if the repricing brought them under the threshold. CMS indicated that it would be open to comments and suggestions for future rulemaking if there is an interest in addressing these equipment items:

Equipment Description	CMS Code	Useful Life	Purchase Price
camera, digital (6 mexapixel)	ED004	5	152.50

Diabetes Educator Curriculum	EQ306	5	200.00
endoscope, ultrasound radial probe	ES045	7	0.00
Injector, Provis (for angiography room)	EL049		0.00
kit, vision	ES058	10	410.00
pulse oxymetry recording software (prolonged monitoring)	EQ212	5	387.00
Respiratory Impedance Plethysmography Belts (pair)	EQ337	5	87.00
Respiratory impedance Plethysmography Belts (pair) (Pediatric)	EQ349	5	199.75
slide warmer	EP051	7	425.59
ultrasound digital scope, endoscopic ultrasound	ES091		0.00
work samples, small tools (Valpar 1)	EQ267	7	361.20

Considering the CMS definition that medical equipment must be at least $500 and all equipment inputs under $500 are considered indirect expense, the RUC agreed that the 11 inputs (above) should no longer be listed as equipment as they are less than $500. **The RUC requests that CMS remove these items from its equipment list and from the specific codes to conform to the definition of direct medical equipment and to ensure that the rule remains consistently applied.**

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 14)

Doctor Gregory DeMeo, Vice Chair, provided the report of the Relativity Assessment Workgroup.

Doctor DeMeo indicated that the Workgroup reviewed 34 action plans representing 64 codes for services identified on the high-volume growth, different performing specialty from survey, contractor-priced, high volume Category III codes, work neutrality (CPT 2022), new technology/new services, and codes reported together 75% or more screens.

High-Cost Disposable Supplies Screen

The Relativity Assessment Workgroup discussed the high-cost disposable supplies screen, noting that for at least the last 20 years, the RUC has continuously requested that CMS separately identify and pay for high-cost disposable supplies (priced at more than $500). The RUC continues to identify and notify CMS of high-cost disposable supplies every time it reviews such an item.

In September 2024, the Workgroup reviewed these services noting that this is a difficult problem to address as there is little input the RUC can provide except pass along paid invoices to CMS for them to price these 82 high-cost disposable supplies. The Workgroup noted that the RUC has iterated that these high-cost disposable supplies need their own supply code, annual review and be paid at cost. However, trying to address via action plans for 157 codes that contain these 82 high-cost disposable supplies may not solve any underlying issues with these services. **Therefore, the Relativity Assessment Workgroup recommends that a joint CPT/RUC Workgroup be formed to address how CMS may address high-cost disposable supplies.**

Do Not Use to Validate Physician Work Flag Screen

At the April 2024 RUC meeting, a RUC member inquired about the Relativity Assessment Workgroup (RAW) reviewing codes that are flagged in the RUC database as "do not use to validate physician work" to see if these codes warrant a screen for re-review.

The Workgroup identified five reasons on why codes have been flagged as "do not use to validate physician work":

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

The Workgroup noted that providing a more granular description of the "do not use" flags in the RUC database would be helpful. AMA staff will work with the Workgroup Chair to determine if additional data or screen may be developed based on some parameters for low survey response flagged codes. **The Workgroup will continue this overall discussion at the January 2025 meeting.**

Referral from CPT - Thyroidectomy (60240 and 60260)
At the October 2021, CPT Editorial Panel meeting, the CPT Executive Committee (EC) referrals were presented to the CPT Editorial Panel. The recommendations of the Executive Committee were accepted through a consent calendar, with the following single extraction:

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

The Workgroup reviewed this referral and recommended that the specialty societies submit an action plan for the January 2025 meeting for CPT codes 60240 and 60260 on how to address these services.

Inpatient Length of Stay
Identifying objective new screens is a charge of the Relativity Assessment Workgroup. Based on other research conducted by AMA staff, inpatient length of stay data and corresponding inpatient hospital visits was identified as a potential screen. AMA staff identified 28 services that are typically performed in the inpatient setting and have more than 10,000 claims in the 2022 Medicare utilization.

An AMA senior economist linked physician Medicare claims data to inpatient Medicare claims data to estimate length of stay for these 28 services. The data utilized was the 2022 Medicare FFS Annual 5% Carrier and Inpatient Claims data. Patients may have undergone multiple procedures during an inpatient stay; thus, length of stay observations in the inpatient file may not solely be attributed to a single procedure code. Also note, that there are no available specific crosswalks between CPT codes and inpatient diagnostic related groups (DRGs).

The estimated length of stay day data for the 28 services does not illustrate any pattern of overestimates of hospital visits included in the surgical global period. It would be difficult to expand this analysis beyond these 28 services due to a lack of an adequate number of observations in claims data. This information is provided to the Relativity Assessment Workgroup to also address the call for the RUC to continue to use all available extant data in evaluating physician services.

The Workgroup reviewed this data and filed it as informational and a responsive effort to seek out possible uses of extant data.

The RUC approved the Relativity Assessment Workgroup Report.

XIV. New/Other Business (Tab 15)

- The RUC Chair thanked departing RUC member, Doctor Scott Collins, for his longtime service on the RUC and asked if he would like to address the room. Doctor Collins applauded the RUC process and how far the committee has come in his tenure. He encouraged new RUC members to reach out to those on the committee with a longer tenure for assistance as they enter the process. He encouraged everyone to continue to do good work and to lean on each other for support.
- A RUC member requested that changes be outlined via track changes in the summary of recommendation (SOR) forms when new forms are submitted prior to and at the meeting. AMA Staff stated that because the documents are macro-enabled, utilizing color, highlight, or track changes is not possible. However, AMA staff do request a summary of what changed when documents are updated. This summary is passed on to the tab reviewers.
- A RUC member commented that an extensive amount of volunteer time is provided by the participants in the room and expressed gratitude toward AMA staff for providing *AMA PRA Category 1™* credits for RUC meeting participation.
- A RUC member expressed concern about artificial intelligence (AI) coding change applications at CPT and RUC that may lead to large reviews of families of existing services. Another RUC member stated that the practice expense (PE) for a given algorithm, when not allocated to a specific patient, is considered overhead and it would be difficult to discern algorithms related to PE at the CPT code level for certain technologies. It was acknowledged that future discussion of AI as it relates to the CPT and RUC processes will be ongoing.

- Doctor Silva held a moment to acknowledge the passing of Doctor Sam Silver and asked Doctor Margie Andreae to say a few words about him in remembrance. Doctor Andreae was honored to speak about Sam and said that he was a dear friend of hers. When she started out in her administrative role about 15 years ago at Michigan medicine, she was given an office in the Dean's suite right next to Sam. Being a newbie in this suite of senior executives was intimidating and Sam would come over to her office and at the end of the day, and he would sit down, and chat about life and his family and patients. Sam had patients from local areas and all over the country; people sought him out for his clinical expertise, and he was just a really amazing, amazing clinician. He was very supportive, and very supportive of her. From those days, all the way up to his last day, she and Sam were emailing back and forth about RUC issues, even just shortly before he passed. Even when he was no longer able to attend meetings, he would send her follow up emails saying that he listened into her research committee meetings and that she did a great job, but she should have done this, or she should have done that. So, he was always giving her some good feedback and she will certainly miss that. He adored his family. He had a couple of kids, and he always made time when he was coming to meetings to make sure to spend time with his kids. He was lucky enough to have a grandchild before he passed to enjoy for a few years. Doctor Andreae mentioned that many RUC participants may have met Sam at one point or another. He was here for many, many years in both an Advisor role as well as a voting RUC member. She was honored to share some memories of Sam and to take a moment to honor Sam, and all that he was for us and what he showed us. Doctor Silva mentioned that his daughter-in-law is a participant of the RUC process and that our sympathies are with her and their family during this time.

The RUC adjourned at 3:23 PM CT on Saturday, September 28, 2024.

AMA/Specialty Society RVS Update Committee **Tab 12**
Research Subcommittee Report
Thursday, September 26, 2024

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

I. Minutes, May 29th Research Subcommittee Specialty Requests Meeting Report Review

The Research Subcommittee report from the May 29th conference call included in Tab 12 agenda materials was approved without modification.

II. Discussion – RUC Use of Crosswalks

At the April 2024 RUC meeting, a RUC member inquired about the number of times a crosswalk code did not have the same global period as the surveyed code (as that was the case for one code at the April 2024 meeting). The RUC referred this issue to the Research Subcommittee for review at the September 2024 meeting.

In September 2024, AMA staff provided the Subcommittee with an analysis of the RUC recommendations for 495 codes from the CPT 2021-2025 RUC cycles which also underwent a RUC survey. 82 (17%) of these recommendations were based on a crosswalk. When the RUC recommendation was based on a crosswalk code, the RUC always recommended an identical work RVU. In addition, both services had identical global period assignments 100% of the time. For a significant number of codes, the RUC recommended time was within 10% of the time for the crosswalk code (87% intra-time and 51% total-time). Every crosswalk code selected had been reviewed by the RUC (100%).

Crosswalk usage data (CPT 2021 – CPT 2025):

Number of RUC Recommendations w/ Crosswalk*	**82**
Identical Work RVUs	**100%**
Identical Global Periods	**100%**
Identical Intra-service Times	**71%**
Intra-Time within 10%	**87%**
Intra-Time within 20%	**91%**
Identical Total Time	**24%**
Total Time within 10%	**51%**
Total Time within 20%	**68%**
IWPUTs within 10%	**70%**
IWPUTs within 20%	**82%**
Crosswalk Code reviewed by RUC	**100%**
Crosswalk Code reviewed by RUC in previous 10 years	**70%**
Medicare Util >1,000	**85%**
MPC List	**15%**
Top 3 Specialties for Crosswalk Code is also a surveying society for the survey code	**45%**

**Only includes codes under review which were surveyed for physician work; excludes same-cycle interim recommendations.*

The Chair noted that at the September 2023 RUC meeting, the RUC approved language regarding crosswalks including that they should have the same global period, be recently reviewed, have similar intra-service time and total time, be clinically similar to the surveyed code, and not be flagged as "Do Not Use to Validate Physician Work" in the RUC database. However, these guidelines are included in the instructions for developing work RVU recommendations document which is for specialty societies developing recommendations and do not limit the RUC or facilitation committees specifically as they review RVU recommendations for a code or code family.

After review of the analysis prepared by AMA staff, the Subcommittee concluded that the RUC has an excellent track record over the past five years of selecting crosswalks that are consistent with the guidelines provided to the specialty societies and no defined requirements for the RUC are indicated. The Subcommittee noted that there were no instances of differing globals for the 5 years prior to the April 2024 meeting. **The Research Subcommittee agreed that no changes were warranted for the RUC's crosswalk methodology.**

III. RUC Intensity and Complexity Survey Questions

During the April 2024 RUC New Business discussion, a RUC member inquired about the intensity/complexity survey questions and the use of "identical" as the midpoint of the five-point comparison scale included in the standard RUC survey templates or if the midpoint should instead state "similar" intensity/complexity compared to the key reference services. The inquiry was based on a concern that survey respondents may be reluctant to select the term "identical" as this implies an exactness. The RUC referred this item for consideration by the Research Subcommittee at the September 2024 meeting.

In September 2024, the Chair noted that the Likert scale is most often five points to allow enough options without overwhelming the respondent. The scale can be used to measure magnitude from low to high (1-5) or measure relativity with two degrees of separation from neutral (strongly agree, somewhat agree, neutral, somewhat disagree, strongly disagree). The RUC intensity survey question measures intensity relative to the KRS using two degrees of separation with neutral where neutral is "identical." Other potential option to express neutral would be to use the terms "similar", "no difference" or "same."

Several Subcommittee members expressed support for switching away from "identical", which many concurred was too exact. Many members expressed support for the term "same". One member suggested "nearly the same". Also, the Subcommittee discussed changing the intensity/complexity question to remove the word "directly" from the following sentence: "Using your expertise, consider how each survey code compares directly to the corresponding reference code." Several Subcommittee members expressed support for this change as well.

The Research Subcommittee determined that the members and staff needed to consider the change, seeking out additional information about the impact of the terms "same" and "identical" in survey research. The Subcommittee did not make a final decision on these changes and will continue this discussion at a future meeting.

IV. Proposed Custom RUC Survey for Lower Extremity Revascularization (LER) Services

The American College of Cardiology (ACC)
The American College of Radiology (ACR)
The American College of Surgeons (ACS)

The Outpatient Endovascular and Interventional Society (OEIS)
The Society for Cardiovascular Angiography and Interventions (SCAI)
The Society for Vascular Surgery (SVS)
The Society of Interventional Radiology (SIR)

At the September 2024 CPT Editorial Panel meeting, the Panel created 46 new CPT code to describe Lower Extremity Revascularization (LER) services and deleted the 16 existing lower extremity revascularization codes. The surveying societies submitted a proposal for surveying these codes for the January 2025 meeting using a custom survey instrument.

Prior to the meeting, the surveying specialty societies submitted a proposal to conduct a standard RUC survey of 10 anchor codes for the family and then conduct an abbreviated survey for the other 46 codes in the same template, with the abbreviated-surveys split into three separate groupings: (1) Tibial – Peroneal, (2) Femoral – Popliteal and (3) Iliac + Inframalleolar. Each physician in the sample would receive a standard RUC survey for the 10 anchor codes and one abbreviated survey. The specialty societies will break up their samples to evenly distribute the abbreviated surveys. The presenters noted that the intent of their proposal is to avoid survey fatigue and to maximize the number of survey responses for each code.

The presenters noted the abbreviated portion of the survey for the remainder of the codes would present the CPT code, CPT descriptor, and Vignette. The respondent would be asked to affirm the vignette, provide Intra Time, Overall Complexity, Estimated Work RVU, and 12 Month Experience without selecting a reference service code. The abbreviated portion of the surveys would also include the survey respondent's answers from the anchor codes populated into the abbreviated survey table to allow comparison. All 000 pre/post time cells in the abbreviated portion of the survey would be pre-populated (editable) based on pre- and post- packages selected for the anchoring codes. For the single intensity/complexity question in the abbreviated portion of the survey, an anchor survey code from the same territory would be provided for comparison/reference.

Subcommittee members overall were supportive of the request for a combined full and abbreviated survey. Several Subcommittee members expressed concern with the initial proposal to divide respondents into three groupings with a preference for two groupings, and also expressed concerns with the group of anchor survey codes not having an angioplasty only service. Subcommittee members requested for the societies to consider switching the abbreviated survey groupings to two groups instead of three. Also, the Subcommittee requested for the societies to reconsider the representation of anchor codes that would receive a full RUC survey. The Chair suggested the societies consider adding a question on the survey to assess the typical number of blockages/stenoses typical for the femoral/ popliteal stent and/or atherectomy/stent codes.

In order to provide additional time to the surveying societies, the Research Subcommittee reconvened the next morning. The societies provided an updated proposal with 11 anchor survey codes which represented every territory in the family, straightforward procedures, complex procedures, angioplasty only procedures, stent placement procedures, atherectomy procedures and add-on procedures. Also, the societies provided two groupings of abbreviated survey codes instead of three. Finally, the societies provided a list of which comparator codes would be used for the intensity/complexity question for each abbreviated survey code (included in the September 2024 handouts at the meeting folder). **The Research Subcommittee approved the custom survey instrument and methodology as follows:**

Research-Approved Core Survey Codes (Standard RUC Survey):

37254 **37255**	Iliac, angioplasty, init, SF + Iliac, angioplasty, addl, SF
37256	Iliac, angioplasty, init, CX
37262	+ Iliac IVL
37267	Fem-Pop, angioplasty stent, init, SF
37268	+ Fem-Pop, angioplasty stent, addl, SF
37269	Fem-Pop, angioplasty ather, init, CX
37288	Tibial, angioplasty ather, init, SF
37289	+ Tibial, angioplasty ather, addl, SF
37290	Tibial, angioplasty ather, init, CX
37296	Inframalleolar, angioplasty, init, SF

Research-Approved Abbreviated Survey Groupings:
Abbreviated Survey Group 1:

37257	+ Iliac, angioplasty, addl, CX
37258	Iliac, angioplasty stent, init, SF
37259	+ Iliac, angioplasty stent, addl, SF
37260	Iliac, angioplasty stent, init, CX
37261	+ Iliac, angioplasty stent, addl, CX
37263	Fem-pop, angioplasty, init, SF
37264	+ Fem-pop, angioplasty, addl, SF
37265	Fem-pop, angioplasty, init, CX
37266	+ Fem-pop, angioplasty, addl, CX
37270	+ Fem-pop, angioplasty stent, addl, CX
37271	Fem-pop, angioplasty ather, init, SF
37272	+ Fem-pop, angioplasty ather, addl, SF
37273	Fem-pop, angioplasty ather, init, CX
37274	+ Fem-pop, angioplasty ather, addl, CX
37275	Fem-pop, angioplasty ather stent, init, SF
37276	+ Fem-pop, angioplasty ather stent, addl, SF
37277	Fem-pop, angioplasty ather stent, init, CX
37278	+ Fem-pop, angioplasty ather stent, addl, CX
37279	+ Fem-pop IVL

Abbreviated Survey Group 2:

37280	Tibial, angioplasty, init, SF

37281	+ Tibial, angioplasty, addl, SF
37282	Tibial, angioplasty, init, CX
37283	+ Tibial, angioplasty, addl, CX
37284	Tibial, angioplasty stent, init, SF
37285	+ Tibial, angioplasty stent, addl, SF
37286	Tibial, angioplasty stent, init, CX
37287	+ Tibial, angioplasty stent, addl, CX
37291	+ Tibial, angioplasty ather, addl, CX
37292	Tibial, angioplasty ather stent, init, SF
37293	+ Tibial, angioplasty ather stent, addl, SF
37294	Tibial, angioplasty ather stent, init, CX
37295	+ Tibial, angioplasty ather stent, addl, CX
37297	+ Inframalleolar, angioplasty, addl, SF
37298	Inframalleolar, angioplasty, init, CX
37299	+ Inframalleolar, angioplasty, addl, CX

Research-Approved Questions for Abbreviated Portio of the Survey

New Codes	**CPT Codes** **CPT Descriptor**	
Typical Patients	**Is your typical patient for this procedure similar to the typical patient described?**	Yes or No
	If no, please describe your typical patient	
Physician Time	**How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? [Pre and Post times piped from package times]**	Pre Eval
		Pre Pos
		Pre SDW
		INTRA
		Imm Pos
		Total Time
Intensity/Complexity	**Compare OVERALL intensity/complexity of all physician work you perform for the new codes relative to [Piped Comparator Code]**	
Physician Work RVUs	**Based on your review of all previous questions, please provide your estimated work RVU (to the 2nd decimal place) for the new codes.**	

Experience	How many times have you personally performed these procedures in the past 12 months?

AMA/Specialty Society RVS Update Committee **Tab 13**
Practice Expense Subcommittee
September 26, 2024

Members Present: Scott Manaker, MD, PhD, (Chair), Amy Aronsky, DO, Gregory Barkley, MD, Michael Booker, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal Cohen, MD, David Han, MD, Katie Jordan, OTD, OTR/L, Mollie MacCormack, MD, Dheeraj Mahajan, MD, Bradley Marple, MD, Tye Ouzounian, MD, Richard Rausch, DPT, Donald Selzer, MD, Elisabeth Volpert, DNP, APRN, Thomas Weida, MD, Adam Weinstein, MD, and Tim Swan, MD (CPT Resource)

I. High-Cost Supplies

At the January 2024 meeting, the Practice Expense (PE) Subcommittee expressed its continued concern with the issue of high-cost supplies and the need to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. At the same meeting, a RUC member suggested that codes with high-cost disposable supplies be flagged for PE re-review.

In April 2024, the PE Subcommittee continued to examine this issue, noting that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting. Moreover, the Subcommittee noted the significant scaling factors that are applied for budget neutrality as part of the PE methodology, which may result in payments that are lower than the cost to provide a service. At the same meeting, the Relativity Assessment Workgroup (RAW) discussed this issue to determine if a useful screen should be developed to identify any potentially misvalued services.

For the September 2024 meeting, the discussion and analysis of the high-cost supplies issue was referred to the RAW meeting (Tab 14). AMA staff provided data which show:

- There are 69 services in which the total practice expense payment does not cover the total direct supply expense for the code.
- There are 53 of these 69 services in which a high cost disposable supply is over $500.
- For 6 of these 53 services, the practice expense payment does not even cover the cost of a single high-cost supply utilized in the provision of the service.

The RAW examined the data and considered whether codes with high-cost disposable supplies should be flagged for PE re-review through development of a High-Cost Disposable Supplies Screen. The Workgroup indicated that it would be part of existing precedent to identify services for PE review only. The Workgroup also discussed whether new invoices should be required for supplies over $500 for the RUC to submit to CMS. Staff emphasized that for nearly 20 years, **the RUC has called on CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The RAW requested formation of a joint CPT and RUC workgroup to address the issue of high-cost disposable supplies.**

II. Radiology-specific Clinical Activities

At the April 2024 RUC meeting, the PE Subcommittee considered the use of Clinical Activity (CA) code CA014 *Confirm order, protocol exam*. The guidelines for this clinical activity specify "For use in imaging services only. 1 minute standard." It was noted that CA014 has been repeatedly requested for non-imaging procedures despite the instructions which state that the task is only for imaging. Further, protocoling exams has a very specific meaning in CT and MRI that describes the work of choosing which

imaging sequences or contrast phases to perform. The task of verifying the correct patient and procedure or medication happens in nearly every procedure (aka the "time out") or medication administration, and is not intended to receive additional time in a relative system. After considering a database search that showed over 20 of the 66 codes with CA014 greater than 0 minutes are non-imaging, **the PE Subcommittee agreed that the CA014 minutes could be allocated in the non-radiology codes.** The Subcommittee discussed how the work being described in the injection and immunization codes, for example, is broadly performed across the code set and is not strictly protocoling.

For the September 2024 meeting, the PE Subcommittee discussed examples for CA014 to include in the *Practice Expense Direct Input Benchmarks* document. For example, CA010 *Obtain vital signs* specifies different levels and vital signs for consistency:

5. The obtaining of vital signs, standardized into 3 levels of service with the following times: Level 0 (no vital signs taken) = 0 minutes, Level 1 (1-3 vitals) = 3 minutes, Level 2 (4-6 vitals) = 5 minutes. (Approved April 2000).

The PE Subcommittee determined updates to the Benchmarks for CA014 to read as follows:

7. **Confirm order, protocol exam, standardized to 1 minute.<u>, e.g., selecting which imaging sequences or contrast phases to perform in CT and MRI. 0 minutes for verifying the correct patient and procedure/ medication (aka the "time out").</u>**

The PE Subcommittee further determined that for the six codes below which state "For use in imaging services," the statement should be removed such that the specialties can justify the 1 or 2 minute standard for each procedure as needed.

CA006	Confirm availability of prior images/studies	General Activity	For use in imaging services. 2 minute standard.
CA007	Review patient clinical extant information and questionnaire	General Activity	For use in imaging services. 1 minute standard.
CA014	Confirm order, protocol exam	General Activity	For use in imaging services. 1 minute standard.
CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	General Activity	For use in imaging services, Baseline time for this activity is 2 minutes.
CA031	Review examination with interpreting MD/DO	General Activity	For use in imaging services, Standard time for this activity is 2 minutes.
CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	General Activity	For use in imaging services, Standard time for this activity is 1 minute.

The PE Subcommittee determined updates to CA006, CA007, CA014, CA030, CA031, and CA032 to simply state: "2 minute standard" or "1 minute standard".

In addition, the Subcommittee specifically discussed the 2 minute standard for CA006. This standard was developed in 2014, and members acknowledged that the review of images using PACS is much quicker, yet the number of images has greatly increased. Thus, two minutes was still found to be appropriate for confirming the availability of prior images/studies.

III. Equipment Inputs Less than $500

CMS definition and rule related to direct medical equipment is that it must be at least $500 and all equipment inputs under $500 are considered indirect expense. The PE Subcommittee discussed that there are eleven equipment items in the current equipment database that are less than the $500 threshold that CMS has established for equipment, as listed below.

Equipment Description	CMS Code	Useful Life	Purchase Price
camera, digital (6 mexapixel)	ED004	5	152.50
Diabetes Educator Curriculum	EQ306	5	200.00
endoscope, ultrasound radial probe	ES045	7	0.00
Injector, Provis (for angiography room)	EL049		0.00
kit, vision	ES058	10	410.00
pulse oxymetry recording software (prolonged monitoring)	EQ212	5	387.00
Respiratory Impedance Plethysmography Belts (pair)	EQ337	5	87.00
Respiratory impedance Plethysmography Belts (pair) (Pediatric)	EQ349	5	199.75
slide warmer	EP051	7	425.59
ultrasound digital scope, endoscopic ultrasound	ES091		0.00
work samples, small tools (Valpar 1)	EQ267	7	361.20

It was surmised that this could be an artifact of the medical supply and equipment repricing project. CY 2022 marked the final year of the 4-year market-based transition for supply and equipment pricing. When the items above were repriced, they should have been removed from the equipment listing when the repricing brought them under the threshold. These items would not be considered supplies as they are reusable. The PE Subcommittee agreed that the equipment inputs listed above should be considered indirect expense like all other equipment under $500.

CMS indicated that it would be open to comments and suggestions for future rulemaking if there is an interest in addressing these equipment items. The Agency noted that "the small number of equipment items with costs under $500 have very low inclusion in CPT codes, aside from ED004, and their costs are so low that they have little effect on the rate setting."

Considering the CMS definition that medical equipment must be at least $500 and all equipment inputs under $500 are considered indirect expense, the PE Subcommittee agreed that the 11 inputs (above) should no longer be listed as equipment as they are less than $500. The RUC should ask CMS to remove these items from its equipment list and from the specific codes to conform to the definition of direct medical equipment and to ensure that the rule remains consistently applied.

IV. Practice Expense Recommendations for CPT 2026

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

Tab	Title	PE Input Changes	Consent Calendar
4	Limb Lengthening/Shortening-Femur	No Changes	
5	Limb Lengthening/Shortening-Tibia	No Changes	

6	Laparoscopic Prostatectomy	Standard 90-day global inputs. Oct 2016 & Sept 2014 RUC Recs (38570, 38571, 38572, 38573) – Reviewed & made no changes.	X
7	Transurethral Robotic-assisted Resection of Prostate	No Changes	
8	Prostate Biopsy Services	Modifications	
9	Cerebral Perfusion & CT Angiography – Head & Neck	Modifications	
10	Colon Motility Services	Modifications	
11	Immunization Counseling	Modifications	

AMA/Specialty Society RVS Update Committee **Tab 14**
Relativity Assessment Workgroup
September 26, 2024

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

I. Review Action Plans

High Volume Growth (15272, 20985, 37220-37235, 92507, 95800)
In April 2024, the Relativity Assessment Workgroup identified five codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. The Workgroup requested that the specialty societies submit an action plan for codes 15272, 20985, 61783, 92507 and 95800 for September 2024. CPT code 61783 was deferred until January 2025. Additionally, codes 37220-37235, lower extremity vascular procedures, were referred to CPT in 2018 and the Workgroup requested an update because a coding solution has not yet occurred. The specialty societies submitted a code change application (CCA) for the September 2024 CPT Editorial Panel and the CPT Editorial made additions, revisions and deletions to the LER codes. **The 46 LER codes will be surveyed and reviewed by the RUC in January 2025**.

In September 2024, the Workgroup reviewed the action plans and recommends:

CPT Code	Recommendation
15272	**Remove from screen.** Overall utilization is appropriate. This service is subject to rigorous documentation requirements to maintain coverage eligibility, as outlined in Medicare LCD A54117. Only one provider stands out by submitting almost 100% of the utilization by pain management providers.
20985	**Refer to CPT.** The specialty society would like to address modify the descriptor and address any overlap with codes 0054T and 0055T. It is expected that revising code 20985 will result in a decrease of the reporting of the T codes.
37220 (f) 37221 (f) 37222 (f) 37223 (f) 37224 (f) 37225 (f) 37226 (f) 37227 (f) 37228 (f) 37229 37230 (f) 37231 (f) 37232 (f) 37233 (f) 37234 (f) 37235 (f)	**Survey for January 2025.** In September 2024, the CPT Editorial Panel deleted 16 lower extremity revascularization codes and one Category III code and revised the "Endovascular Revascularization (Open, Percutaneous, Transcatheter) guidelines and parenthetical revisions throughout the code set. The Panel added a new subsection titled, "Iliac Vascular Territory" accompanied by nine new codes; added a new subsection titled, "Femoral and Popliteal Vascular Territory" accompanied by 17 new codes; added a new subsection titled, "Tibial and Peroneal Vascular Territory" accompanied by 16 new codes; and added a new subsection titled, "Inframalleolar Vascular Territory" accompanied by four new codes. **These 46 codes will be surveyed and reviewed by the RUC in January 2025.**

92507	**Refer to CPT** to reflect current practice patterns and modernize the descriptions of treatment services currently captured under CPT code 92507.
95800	**Refer to CPT**. The specialty societies submitted a CCA for Sept 2024 CPT meeting to delete the current code family and replace it with a set of codes that more accurately reflect current medical practice and technologies. However, this tab was withdrawn at CPT due to the many issues identified by the Panel reviewers. The specialty societies indicated that they have drafted a new CCA and plan to submit it for the February 2025 CPT meeting.

Different Performing Specialty from Survey (11305, 11308, 28750, 77280, 94625, 96112)

In April 2024, the Relativity Assessment Workgroup identified six codes where the top two dominant specialties performing services based on 2022 Medicare utilization more than 10,000 and where the top specialty performing over 50% of the Medicare claims did not survey the service or the top two specialties did not survey the service. The Workgroup requested action plans for codes 11305, 11308, 28750, 77280, 94625 and 96112 for September 2024. **In September 2024, the Workgroup reviewed the action plans and recommends:**

CPT Code	Recommendation
11305 11308	**Refer to CPT Assistant** to specifically address correct coding for shaving versus paring and accurate reporting of 11300-11313 versus 11055-11057.
28750	**Survey for January 2025 with applicable family of services.** This service was last valued in 1995, podiatry performs 57% of this service and was not involved in the survey, and this service should be evaluated relative to other services within the family that have changed.
77280	Addressed via CPT. The specialty societies submitted a CCA for the September 2024 CPT meeting. The CPT Editorial Panel added four codes and a new subsection to report surface radiation therapy and deleted codes 77401 and 0394T. The coding changes appropriately describe superficial radiation, performed typically by dermatology. Therefore, Dermatology will report the new services and should no longer report 77280.
94625	**Maintain**. Follow up with this service on the new technology list (April 2026) and review after additional data is available.
96112	**Review in 3 years (September 2027).** A few Nurse Practitioners are performing 40% of these services. Notify CMS that there may be misreporting of this service.

Contractor-Priced High Volume (G0498)

In April 2024, the Relativity Assessment Workgroup identified one code with 2022 Medicare utilization over 10,000 and Medicare status of "C" contractor priced. The Workgroup requested an action plan for G0498 for September 2024. **In September 2024, the Workgroup reviewed the action plan and recommends:**

CPT Code	Recommendation
G0498	**Maintain**. G0498 was created to allow for payment for a **non-implantable** portable infusion pump. CPT code 96416 is for portable or implantable pump. The valuation process does not allow for inclusion of the portable pump expense because the pumps are typically provided through DME rental agreements which represent a rental expense.

High Volume Category III Codes (0552T, 0599T)
In April 2024, the Relativity Assessment Workgroup identified two Category III codes with 2022 Medicare utilization over 1,000. The Workgroup noted that once identified, action plans are requested for the Category III high volume codes. These services are identified to notify and get feedback from specialty societies whether a Category I code should be created. The Workgroup requested action plans for codes 0552T and 0599T for September 2024. **In September 2024, the Workgroup reviewed the action plans and recommends:**

CPT Code	Recommendation
0552T	**Maintain** as Category III. Only three NPIs reporting this service the CMS Medicare Physician & Other Practitioners - by Provider and Service 2022 data.
0599T	**Review in 2 years**. Low utilization and the top five providers make up about half of the current utilization in the CMS Medicare Physician & Other Practitioners - by Provider and Service 2022 data.

Work Neutrality CPT 2022 (94625, 94626)
In April 2024, the Relativity Assessment Workgroup identified one issue for codes that were reviewed for CPT 2022 (April 2020, October 2020, and January 2021) that have more than 10% increase in work RVUs from what was projected. The Workgroup requested and action plan Outpatient Pulmonary Rehabilitation Services (94625 & 94626) for September 2024. **In September 2024, the Workgroup reviewed the action plan and recommends to maintain 94625 and 946426 and follow up when they appear on the on the new technology list (April 2026) for review after additional data is available.**

New Technology/New Services

Transcranial Magnetic Stimulation (90867-90869)
At the April 2024 meeting, the Workgroup reviewed an action plan for 90867-90869 and requested to review a new action plan in September 2024 with an update from the specialty society. The specialties indicated that there are changes in protocol for these services and coding changes are necessary. These codes are also contractor priced. The Workgroup questioned what specific coding changes would be included in a CCA. The specialty society will return in September to elaborate on the coding changes necessary. The specialty societies should also consider any Category III codes that are related to these services when drafting their CCA. In September 2024, the specialty societies submitted an action plan requesting that codes 90867-90879 be referred to CPT Editorial Panel to modify the existing codes as well as develop a technology agnostic code or set of codes for the May 2025 CPT meeting/September 2025 RUC meeting. **The Workgroup recommends that 90867-90869 be referred to CPT May 2025 meeting.**

Chronic Care Remote Physiologic Monitoring (99453-99458)
At the April 2024 meeting the Workgroup reviewed an action plan for 99453-99458 and requested to review September 2024 with an update from the specialty societies. A CCA for remote monitoring was reviewed at the September 2024 CPT Meeting which included codes 99453-99458. **CPT codes 99453-99458 will be surveyed and reviewed at the January 2025 RUC meeting.**

Services Performed Together 75% or More (18 code pairs)
In April 2024, the Relativity Assessment Workgroup identified 16 code pairs for services performed by the same physician on the same date of service 75% of the time or more. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the

codes was either below 1,000 in 2022 Medicare claims data and/or contained at least one ZZZ global service were removed. The Workgroup requested action plans for September 2024 to determine if specific code bundling solutions should occur for the following code pairs. **The Workgroup reviewed the action plans and recommends:**

CPT Code 1	CPT Code 2	Percent Billed Together	Recommendation
13152	17311	76%	**Review in 1 year (September 2025)** to determine if these services are still being reported together more than 75% of the time.
31525	31231	80%	**Review in 3 years (Sept 2027).** Data shows possible misreporting by one practice driving utilization, the specialty society already notified CMS.
31525	69210	75%	**Review in 3 years (Sept 2027).** Data shows possible misreporting by one practice driving utilization, the specialty society already notified CMS.
77301	77300	79%	**Maintain** to allow for continued component coding PC/TC. The physician work is separate, direct practice expenses are separate, the number of units of these two vary so need to maintain separate codes. CPT code 77301 is for planning and 77300 is a dose calculation for each field (some have 3 fields some have 9 fields). Some may report 77301 once but with many 77300 and need to allow for this variation.
77301	77338	88%	**Maintain** to allow for continued component coding PC/TC.
77338	77300	81%	**Maintain** to allow for continued component coding PC/TC.
77338	77301	80%	**Maintain** to allow for continued component coding PC/TC.
77401	77280	77%	Addressed via CPT. The specialty societies submitted a CCA for the September 2024 CPT meeting. The CPT Editorial Panel added four codes and a new subsection to report surface radiation therapy and deleted codes 77401 and 0394T. The family of new codes includes a combination of professional/technical services to allow for the reporting of services performed.
77600	77280	94%	Addressed via CPT. The specialty societies submitted a CCA for the September 2024 CPT meeting. The CPT Editorial Panel added four codes and a new subsection to report surface radiation therapy and deleted codes 77401 and 0394T. CPT codes 77600 and 77280 appear in parentheticals as not to be reported with new surface radiation therapy codes, which will address the bundling issue.
92546	92540	84%	**Refer to CPT.** Revise code 92546 descriptor to clarify the service and it should no longer typically be reported with code 92540, more than 75% of the time. Maintain 92540 and re-review after CPT changes and new billed together data is available (2029).
92550	92557	90%	**Maintain**. Each code provides separate and distinct diagnostic information and the existing construct allows the clinician to select the appropriate test battery based on patient presentation.
92567	92557	85%	**Maintain**. Each code provides separate and distinct diagnostic information and the existing construct allows the clinician to select the appropriate test battery based on patient presentation.
93016	93018	77%	**Maintain**. This code combination is being properly reported through component coding.

95861	95938	86%	**Maintain**. These services do not present duplication in work as there are distinct activities that occur in the pre and post service period which necessitate reporting each individual code.
95921	95923	87%	**Refer to CPT**. The specialty societies submitted a CCA for the Sept 2024 meeting with revisions to the current autonomic function testing code set and the creation of a new Category I code to more accurately reflect current clinical practice and technologies. However, this issue was withdrawn from CPT based on feedback from specialty society comments and Editorial Panel reviewers. The specialty societies will revise the CCA to address concerns with reported together utilization The specialty societies will resubmit a CCA for the February 2025 CPT meeting.
95939	95938	95%	**Maintain**. These services do not present duplication in work as there are distinct activities that occur in the pre and post service period which necessitate reporting each individual code. They are performed on the same day when both the sensory and the central motor pathways need to be evaluated.

II. High-Cost Disposable Supplies Screen

In January 2024, a RUC member suggested that codes with high-cost disposable supplies be flagged for PE re-review. For at least the last 20 years, the RUC has continuously requested that CMS separately identify and pay for high-cost disposable supplies (priced at more than $500). The RUC continues to identify and notify CMS of high-cost disposable supplies every time it reviews such an item.

Additionally, as recent as the January 2024 RUC meeting, *"The PE Subcommittee expressed its continued concern with the issue of high-cost supplies and the outsized impact these items have within the current practice expense RVU methodology.* ***The RUC will continue to call on CMS to separately identify and pay for high-cost disposable supplies (i.e., priced more than $500) using appropriate HCPCS codes."***

In April 2024, the Practice Expense Subcommittee continued to examine this issue. The PE Subcommittee noted that the 2024 Medicare Physician Payment Schedule includes 82 supply items with a purchase price of more than $500. These high-cost supplies represent $1.26 billion in direct costs for 2024 and 18 percent of all practice expense supply costs in the non-facility setting.

The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. Because of specialty pools and how the PE formula derives the code-level indirect practice expense in part as a multiple of the code-level direct practice expense inputs, when CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service which is subsidized by the broader specialty and all other Medicare providers. If high-cost supplies were paid separately with appropriate HCPCS codes, the indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services.

In April 2024, the Relativity Assessment Workgroup discussed this issue to determine if a useful screen should be developed to identify any potentially misvalued services. The Workgroup noted that there are significant scaling factors that are applied for budget neutrality as part of the PE methodology, which may result in payments that are lower than the cost to provide a service. The Workgroup indicated that it would be part of existing precedent to identify services for PE review only.

For September 2024, AMA staff pulled the data which show:

- There are 69 services in which the total practice expense payment does not cover the total direct supply expense for the code.
- There are 53 of these 69 services in which a high-cost disposable supply is over $500.
- For 6 of these 53 services, the practice expense payment does not even cover the cost of a single high-cost supply utilized in the provision of the service.

In September 2024, the Workgroup reviewed these services noting that this is a difficult problem to address as there is little input the RUC can provide except pass along paid invoices to CMS for them to price these 82 high-cost disposable supplies. The Workgroup noted that the RUC has iterated that these high-cost disposable supplies need their own supply code, annual review and be paid at cost. However, trying to address via action plans for 157 codes that contain these 82 high-cost disposable supplies may not solve any underlying issues with these services. **Therefore, the Relativity Assessment Workgroup recommends that a joint CPT/RUC Workgroup be formed to address how CMS may address high-cost disposable supplies.**

III. Do Not Use to Validate Physician Work Flag Screen

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

The following groupings of rationale for the "do not use" flag were identified:

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

The Workgroup noted that providing a more granular description of the "do not use" flags in the RUC database would be helpful. AMA staff will work with the Workgroup Chair determine if additional data or screen may be developed based on some parameters for low survey response flagged codes. **The Workgroup will continue this overall discussion at the January 2025 meeting.**

IV. Referral from CPT - Thyroidectomy (60240 and 60260)

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

> Tab I: Other Business - Issue 2: Tab 28 - Thyroidectomy 60260 Parenthetical Deletion
> The Panel Chair provided an overview of the issue, which was derived from a previous CPT Assistant Editorial Board recommendation regarding proper coding for CPT code 60260. Specifically, the Editorial Board was seeking clarity on whether the code referred to removal of a lobe of the thyroid, or to removal of all remaining thyroid tissue.

> The AAO-HNS attempted to address this issue via a CCA (Tab 28) submitted for the October 2021 meeting. However, based on additional feedback from the ACS Advisors and Panel reviewers, it was withdrawn prior to the meeting. Given the withdraw, the EC, during their deliberations, discussed potential next steps.
>
> The Panel discussed precedent for sending something back to the RUC. The EC members noted that while this may be rare, it provided an opportunity for the RUC to potentially address an issue that goes beyond just code structure. Furthermore, having the issue tracked as part of a RUC screen/issue may ensure the issue gets addressed through additional mechanisms for tracking and feedback.
>
> The Panel approved the EC recommendation to refer this issue to the RUC to further consider whether CPT codes 60240 and 60260 represent a rank order anomaly.

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

V. Inpatient Length of Stay

Identifying objective new screens is a charge of the Relativity Assessment Workgroup. Based on other research conducted by AMA staff, inpatient length of stay data and corresponding inpatient hospital visits was identified as a potential screen. AMA staff identified 28 services that are typically performed in the inpatient setting and have more than 10,000 claims in the 2022 Medicare utilization.

An AMA senior economist linked physician Medicare claims data to inpatient Medicare claims data to estimate length of stay for these 28 services. The data utilized was the 2022 Medicare FFS Annual 5% Carrier and Inpatient Claims data. Patients may have undergone multiple procedures during an inpatient stay; thus, length of stay observations in the inpatient file may not solely be attributed to a single procedure code. Also note, that there are no available specific crosswalks between CPT codes and inpatient diagnostic related groups (DRGs).

The estimated length of stay day data for the 28 services does not illustrate any pattern of overestimates of hospital visits included in the surgical global period. It would be difficult to expand this analysis beyond these 28 services due to a lack of an adequate number of observations in claims data. This information is provided to the Relativity Assessment Workgroup to also address the call for the RUC to continue to use all available extant data in evaluating physician services.

The Workgroup reviewed this data and filed it as informational and a responsive effort to seeking out possible uses of extant data.

VI. Informational Items

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