AMA/Specialty Society RVS Update Committee
The Renaissance Chicago Downtown Hotel, Chicago, IL
September 24-27, 2025

Meeting Minutes

I. Welcome and Call to Order

The RVS Update Committee (RUC) met in person in September 2025. Doctor Ezequiel Silva, III, called the meeting to order on Thursday, September 25, 2025, at 2:11 p.m. CT. The following RUC Members and RUC Alternates were in attendance:

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

RUC Alternates:
Megan Adamson, MD
Eileen Brewer, MD
Neal Cohen, MD
Patrick Godbey, MD
David Han, MD
John Heiner, MD
Gwenn V. Jackson, MD
Kevin Kerber, MD
Thomas Kintanar, MD
Timothy Laing, MD
Mollie MacCormack, MD
Lance Manning, MD
John McAllister, MD
Lauren Nicola, MD
Michael Perskin, MD
Noah Raizman, MD
Sanjay A. Samy, MD
Christopher Shale, MD
Clarice Sinn, DO
Michael Sutherland, MD
Thomas Turk, MD
Korinne Van Keuren, DNP, MS, RN
David Yankura, MD
Robert Zwolak, MD

II. Chair's Report

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

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

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

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

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

- Doctor Silva welcomed the following Member of the CPT Editorial Panel:
  - Lawrence Simon, MD – CPT Editorial Panel Member

- Doctor Silva acknowledged the Centers for Medicare & Medicaid Services (CMS) Medical Officers attending both in person and virtually:
  - Stefanie Fischell, MD
  - Edith Hambrick, MD
  - Emily Yoder
  - Hannah Ahn, PhD

  - Perry Alexion, MD
  - Lindsey Baldwin
  - Erick Carrera, JD
  - Zehra Hussain
  - Sarah Leipnik
  - Mikayla Murphy
  - Jake Quinton, MD
  - Julie Rauch
  - Terry Simananda
  - Pam West

- Doctor Silva recognized U.S. Government Accountability Office (GAO) attendees joining both in person and virtually:
  - Lisa Minich, PhD
  - Kelly Krinn, MPP
  - Leslie Gordon
  - Greg Giusto
  - Xiaoyi Huang
  - Dani Sosa
  - Mela Brown

- Doctor Silva acknowledged those attending virtually from the Office of Inspector General (OIG):
  - Laura Behnke
  - Vlada Hutton
  - Janet McLeod
  - Nicki Stauffacher

- Doctor Silva acknowledged the Medicare Payment Advisory Commission (MedPAC) virtual attendee:
  - Rachel Burton, MPP – Principal Policy Analyst

- Doctor Silva welcomed a special guest:
  - Nate C. Apathy, PhD – Assistant Professor of Health Policy & Management, The University of Maryland School of Public Health
  - EHR (Electronic Health Record) data availability
  - www.nateapathy.com

- Doctor Silva welcomed the AMA's new Chief Executive Officer and Executive Vice President:
  - John Whyte, MD, MPH

Doctor Whyte took a moment to express his appreciation to the RUC participants, noting that the AMA values its role as a convenor of physicians and other health care professionals.

- Doctor Silva recognized the new RUC members:
  - Mark T. Villa, MD – American Society of Plastic Surgeons (ASPS)

- Doctor Silva recognized the new RUC alternate members:
  - Christopher Shale, MD – American Society of Plastic Surgeons (ASPS)

- Doctor Silva recognized dedicated departing RUC participants:
  - Jeffrey P. Edelstein, MD (AAO)
    - RUC Member 2019-2025
    - RUC Alternate 2009-2019
  - Charles Mabry, MD (ACS)
    - 30 years of service in the RUC process!
  - Catherine Hill
    - Specialty Society Staff since 1998 (AANS/CNS 2001-2025)

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

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

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

- Doctor Silva stated the following procedural guidelines related to RUC Ballots:
  - All RUC members and alternates were sent a voting repository with links via email to submit a ballot if the initial vote does not pass.

  - If a tab fails, all RUC Members must complete a ballot to aid the facilitation committee.
  - You must enter the work RVU, physician times and reference codes to support your recommendation.

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

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

- Doctor Silva acknowledged a recent meeting with CMS regarding the Proposed Rule:
  - Aug 27, 2025 met with Chris Klomp, Deputy Director and Administrator
  - Discussion was consistent with RUC comments submitted on the Proposed Rule for 2026

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 RUC appointments and nominations:
  - RUC Member reappointment/appointments letters
  - Primary care rotating seat memo
  - Internal medicine rotating seat letters
  - Due to Sherry.Smith@ama-assn.org by November 14, 2025
  - Rotating seat elections will occur at the January 14-17, 2026 RUC meeting

- Ms. Smith reviewed the RUC Database application – 2025 v 2.0:
  - The RUC database is available at https://rucapp.ama-assn.org
  - Orientation is available on YouTube at https://youtu.be/3phyBHWxlms
  - Accessible both online and offline from any device, including smartphones and tablets.
  - Download the offline version. You will be prompted whenever there is an update available.
  - Be sure to clear caches and log off before downloading a new version.
  - Access has been granted to all RUC participants using the same Microsoft account that you already use to access the RUC Collaboration Website.
  - The database reflects 2023 Medicare claims data and the updated 2025 Conversion Factor (CF).
  - Includes more specific Do Not Use to Validate Physician Work Flags.

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

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

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

- Ms. Smith announced that the RUC now offers Continuing Medical Education (CME) credits for RUC Meeting Participation:
    - Physicians can earn up to 32.00 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 3, 2025.
    - Once you've successfully completed the evaluation, a certificate will be automatically available on October 17, 2025, in the "Transcript" section of your AMA Ed Hub account.

IV. Approval of Minutes from the April 2025 RUC Meeting

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

V. CPT Editorial Panel Update

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

- Panel Meeting Activity – May 2025
    - RUC Referrals Reviewed at the May 2025 Panel Meeting:
        - Decompression Procedure-Delete 62287 (Tab 12)
        - Femoral Osteoplasty-Delete 27468 (Tab 16)
        - Rotational Vestibular Assessment (Tab 49)

- Panel Meeting Activity – September 2025
    - RUC Referrals Reviewed at the September 2025 Panel Meeting:
        - Osteotomy Guideline Revisions, Spine 22210-22216 (Tab 7)
        - Central Venous Catheter Insertion Services (Tab 22)- withdrawn
        - Prostate Biopsy Services (Tab 29)
        - Magnetic Resonance Angiography (MRA)-Head, Neck (Tab 38)

        - Biofeedback Training (Tab 48)
        - Speech-Language Pathology Services (Tab 52)

- September 2025 CPT Editorial Panel Meeting
    - 92 Code Change Applications (CCAs) Submitted
        - Notable agenda items:
            - 8 Digital medicine related CCAs
            - 28 Category III code applications
- Prostate Biopsy Services (Tab 29)
    - Stakeholders expressed confusion with previous descriptors regarding number/type of biopsies. Concern for inconsistent reporting/miscoding.
    - Changes considered include:
        - Replace "sextants" with "regions" to simplify terminology.
        - Four codes now cover all regional/systematic biopsies.
        - Clarify use of fusion-targeting (MRI-US) and in-bore CT/MRI guidance.
        - Add-on codes specify additional lesions.
        - Delete two codes
    - Coding clarifies biopsy reporting and aligns with current clinical practice.

- Maternity Care Services (Tab 30)
    - Stakeholder concerns regarding current maternity code set:
        - Lack sufficient granularity to match contemporary practice and quality reporting standards.
        - Limited ability to study outcomes, address maternal morbidity/mortality, and design accurate payment models—particularly impacting rural practices.
    - Proposed revisions provide additional granularity to support quality care and stab match contemporary practice patterns:
        - Antepartum visits & transfers from rural to tertiary care
        - Granular codes for inductions & prolonged labor
        - Expanded postpartum monitoring codes (hemorrhage, cardiac, mental health)

- CPT Ad Hoc Workgroups
    - Maternity Care Services Workgroup
        - Co-Chairs: Padma Gulur, MD and Timothy L. Swan, MD
        - Code change application from May 2025 CPT Editorial Panel Meeting postponed time certain (September 2025) with specific recommendations.
        - The workgroup met on May 28 and again on June 3 to address the Panel's directives.
        - Extensive edits were made at these meetings to both address Panel recommendations and to further clarify Guidelines and Introductory Language.
        - New CCA submitted for the September 2025 CPT Editorial Panel meeting (Tab 30).
        - No substantive advisor or interested party comments received. Most specialty societies supported this new proposal.

    - Value Based Care Services Workgroup
        - CCA submitted (Tab 95) for the September 2025 CPT Editorial Panel meeting:

- Revisions to the guidelines to expand the members of the care team whose time can be included in the overall time of the service, provided the care team member is under the direction of a physician or other Qualified Health Professional (QHP).
- Addition of clarifying language on the type of supervision of the care team that is required.
- Expansion of services to indicate that electronic means are included.

▪ Phase 2 charge finalized:

- In alignment with the insights received from the comprehensive market feedback and analysis presented to the Panel, the AMA CPT Value-Based Care Workgroup is tasked with advancing the CPT code set to reflect innovations in value-based care. The Workgroup will guide efforts to modernize coding structures, such as episode-based models, to align with contemporary care delivery systems.

o Digital Medicine Coding Committee (DMCC)

▪ Co-Chairs: Richard Frank, MD, PhD/Mark Synovec, MD
▪ The workgroup has frequently met virtually since the May CPT Editorial Panel Meeting, both as an internal workgroup and hosting stakeholder calls.
▪ After much discussion, a CCA (not up for Panel vote) was submitted for the September CPT Editorial Panel meeting to allow both written and open comments from additional specialty societies and interested parties.
▪ Next steps: Continue open dialogue at the September Panel meeting and submit a CCA for February 2026.

- Upcoming CPT Editorial Panel Meetings
  - The next Panel meeting is February 5-7, 2026 (Thursday-Saturday) – Palm Springs, CA
  - The next application submission deadline is November 3, 2025.

- Doctor Simon addressed questions from attendees:
  - A RUC member inquired about the initiation and status of the Value Based Care (VBC) Workgroup (VBC). AMA staff clarified that the workgroup originated from a study commissioned by the AMA in 2024 that synthesized important feedback from each sector of the health care ecosystem to understand how the CPT code set supports current value-based care arrangements and where there are opportunities for continued evolution. As an outcome of this research, the CPT Editorial Panel created the Value-Based Care Workgroup. The workgroup has two AMA RUC Representatives appointed, Doctors Harris and Hollmann. The VBC workgroup is charged with evaluating how the CPT code set can more accurately reflect the clinical and operational realities of VBC models, which are increasingly team-based, digital and focused on outcomes. Through this workgroup, the CPT Editorial Panel is exploring:
    - Episode-based approaches that reflect care delivered across time and teams.
    - To align coding more directly with clinical impact and outcomes.
    - Modernizing code structures to better reflect team-based and digital-first models.

VI. Centers for Medicare & Medicaid Services Update

Emily Yoder, Deputy Director of the Division of Practitioner Services, remarked that she has attended RUC meetings since she was first an analyst at the Centers for Medicare & Medicaid Services (CMS). She conveyed to the RUC that CMS is "…so appreciative of the work that you do, the work that you're doing today, and the work that you do overall in, providing these recommendations to CMS, they are indispensable to us."

VII. Contractor Medical Director (CMD) Update

Janet Lawrence, MD, MS, FACP Contractor Medical Director (CMD), National Government Services, was unable to attend but provided information for a brief CMD update.

- Upcoming Local Coverage Determinations (LCD's)
    - Allergy Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) -Finalizing
    - Comment Period Closed for the Following
        - DL 38378 Transurethral Waterjet Ablation of the Prostate
        - DL39756 Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancer (NMSC)
        - DL40261 Peripheral Nerve Block Procedures (will replace existing LCD)
        - DL 33952 Temporary Nontherapeutic Ambulatory Cardiac Monitoring Devices (will replace Cardiac Event Detection)
        - Botulinum

VIII. Washington Update

Jennifer Hananoki, JD, Director, Federal Affairs, AMA, provided the Washington report focusing on AMA comments on the 2026 Medicare Physician Payment Schedule proposed rule, Merit-based Incentive Payment System (MIPS), Alternative Payment Models (APMs) and Centers for Medicare & Medicaid Services Innovation Center (CMMI) models. Please see full presentation attached for more details.

AMA Comments: 2026 Medicare Physician Payment Schedule Proposed Rule

- AMA Comment Letter and Press Release
    - "In submitting comments today on the 2026 Medicare Physician Fee Schedule, the American Medical Association (AMA) offered to work with CMS on policy changes that aim to preserve private practice and maintain access to health care…
    - The AMA noted that two CMS proposals, however, inadvertently go in the opposite direction of bolstering private practice…
    - The AMA looks forward to continuing the dialogue to ensure that the policy recommendations make Medicare work for our patients and physicians."

- Ms. Hananoki went over proposed 2026 Medicare Conversion Factors

- AMA Comments: Permanent Updates Needed
    - The AMA appreciates that Congress provided a one-year 2.5 percent update to 2026 Medicare physician payments.

  - Despite temporary updates in four of the last five years, Medicare physician payment has continued to erode as economic pressures on physician practices, including rising costs of rent, wages, supplies, and administrative burdens, have intensified.
  - The Administration should support any congressional action to enact inflation-based updates for physician payments, such as the provision tied to the Medicare Economic Index (MEI) that was in the House-passed reconciliation bill.

- Ms. Hananoki talked about how Medicare physician payment continues to fall further behind practice cost inflation

- Patient Access at Risk
  - "This larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals." -Medicare Payment Advisory Commission (MedPAC)
  - "Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare participating physicians to become a significant issue in the long term." -Medicare Trustees

- Practice Expense – Site-of-Service Differential
  - CMS proposes to reduce the work RVU input for the facility indirect PE RVU formula to 50 percent of the amount used for non-facility PE RVU computation
    - CMS is concerned that the current indirect PE methodology may incentivize care in higher-cost settings
    - CMS believes Medicare is making duplicative payments for physicians' practice expenses under Medicare Physician Payment Schedule (MPFS) and facility payment system
  - The AMA agrees that payment should be accurate across sites of service and independent physician practice must remain financially viable.
  - However, we are concerned about unintended consequences of this proposal.
  - The AMA urges CMS to work with us to consider the new 2024 AMA Physician Practice Information (PPI) Survey results more fully, which includes updating the practice expense per hour (PE/HR) groupings and specialty data from the 2024 AMA PPI Survey.

- Efficiency Adjustment
  - CMS proposes to decrease the work RVUs and/or physician intra-service time for 95% of physician services by -2.5% and to apply additional reductions every three years.
    - Exemptions for 389 codes including time-based services, evaluation and management (E/M), care management, maternity care, and services on the telehealth list
    - This cut is based on the last 5 years' productivity adjustments in the MEI
    - CMS' rationale:
      - Physician time is inflated with criticism of utilizing physician surveys to estimate physician time and a call for other time data to augment survey data
      - Concern about the timeliness of review of individual services, resulting in unaddressed potential efficiencies due to changes in clinician expertise, workflows and technology

- "Passive devaluation" of E/M and general goal of increasing payment for primary care services

- AMA Comments
  - The AMA agrees with CMS' goal of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care payment is adequate
  - The AMA recommended that alternative solutions be considered to accomplish these objectives, including:
    - Consider ensuring that higher volume codes be reviewed on a more frequent basis
    - Continue to support the use of surveys to ensure the clinical expertise of physicians and other health care professionals is respected and utilized in establishing work RVUs and the RUC will utilize additional time data sources to augment the physician surveys
    - Implement a correction to the utilization assumptions for G2211, leading to a positive $1 billion budget neutrality adjustment to the Medicare conversion factor

- Ms. Hananoki addressed the combined impact of efficiency adjustment and practice expense site-of-service differential

- Telehealth
  - The AMA recommends that CMS:
    - Work with Congress to permanently extend Medicare telehealth policies;
    - Finalize its proposals to permanently lift the frequency limits on telehealth hospital and nursing facility visits and allow virtual direct supervision except for services with a 10- or 90-day global period;
    - Maintain or expand the ability for teaching physicians to provide virtual supervision of residents in metropolitan as well as non-metropolitan areas;
    - Finalize its proposal to streamline the process for adding services to the Medicare Telehealth List; and
    - Permanently remove the requirement that physicians report their home address.

- Additional Key Topics
  - CMS proposed to accept 89% of the AMA/Specialty Society RUC recommendations for new/revised CPT codes and codes identified via the RUC's potentially misvalued services process.
  - AMA reiterated strong support for the longstanding RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate codes and transparency pricing of these supplies.
  - AMA urged CMS to implement the RUC's recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits and office visits be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day.

Merit-based Incentive Payment System (MIPS)

- 2026 MIPS Proposals and AMA Comments
  - AMA supports CMS' proposals to:
    - Maintain the performance threshold to avoid a penalty at 75 points from 2026 through 2028
    - Fine tune attribution for the Total Per Capita Cost measure but maintains this measure is holding physicians accountable for costs outside their control
    - Establish a two-year, informational-only feedback period for new cost measures

- 2026 MIPS Value Pathways (MVPs)
  - CMS proposed 6 new MVPs and reiterated it plans to move to mandatory MVPs in the future
    - Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, Vascular Surgery
  - AMA encourages CMS to incentivize MVP reporting and continues to oppose mandating it.
  - AMA also urged CMS to rescind or postpone mandatory subgroup reporting for multi-specialty practices to participate in MVPs.

- 2023 MVP Data and Current Survey
  - 1.26% of MIPS eligible clinicians received a MIPS score through an MVP
    - 98 groups, 5 subgroups, and 83 individuals.
  - Of the 12 different MVPs available in 2023, more than half of the entities participated in two: the Cancer Care MVP and the Anesthesia MVP.
  - Although the Wellness MVP had the third largest number of clinicians involved (902), this was based on the participation of just six groups.
  - MVP Adoption Survey – CMS is seeking input and awarding Improvement Activity credit for completing the 10-minute survey

- 2024 MIPS Final Scores Released
  - CMS released 2024 MIPS final scores and performance feedback
  - 2024 final scores impact your Medicare Part B payments in 2026
  - If there are errors, submit a targeted review request (or appeal)
  - More information from CMS:
    - 2024 MIPS Performance Feedback FAQs
    - 2024 Targeted Review User Guide

Alternative Payment Models (APMs) and CMMI Models

- 2026 APM Proposals and AMA Comments
  - AMA urged CMS to adopt its proposal to add an individual level calculation in addition to APM Entity-level calculations for purposes of making QP and Partial QP determinations starting with the 2025 performance year, rather than the 2026 performance year.
  - QP thresholds have increased significantly this year from 50 to 75 percent of payments and 35 to 50 percent of patients.

  - Advanced APM lump sum bonuses also expired at the end of the 2026 payment year (which is based on participation in 2024).

- Medicare Shared Savings Program Accountable Care Organizations (ACOs)
  - AMA recommends exceptions for ACOs in rural or underserved areas and those serving medically or socially complex patients to CMS' proposal to reduce the time allowed in one-sided risk from 7 to 5 years
  - AMA supports:
    - Flexibilities for new ACOs to meet 5,000 assigned patient minimum
    - Expansion of the extreme and uncontrollable circumstance policies for ACOs to obtain relief from performance requirements to include a cyberattack.
    - Allowing mid-year participant list changes in change-of-ownership scenarios.

- Ambulatory Specialty Model (ASM)
  - New mandatory payment model for 7 specialties that treat patients with heart failure or low back pain in certain areas between 2027 and 2031
    - Anesthesiology, cardiology, interventional pain management, pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation
  - Structured like MIPS and adjusts payments by +/- 9% up to +/- 12%
  - Pros:
    - AMA has been urging CMMI to develop specialty models for > 10 years
    - Independent practices can participate; not limited to hospitals or ACOs

- ASM Opportunities for Improvement
  - The AMA strongly urged CMS to redesign ASM as a voluntary model.
  - CMS should also set a performance standard in advance instead of using a "tournament" approach.
  - CMS should increase the patient threshold from 20 patients with heart failure or low back pain a year.
  - CMS should redistribute 100% of funding for payment adjustments and not just 85% of it, which leads to most physicians facing penalties.
  - Steep penalties could lead private practices to seek to join a larger practice or become employed.

- Wasteful and Inappropriate Service Reduction Model (WISeR) Model
  - January 1, 2026, to December 31, 2031, in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.
  - Requires prior authorization or pre-payment review for certain services (e.g., skin and tissue substitutes and cervical fusion)
  - Vendors will utilize AI and human reviews to make coverage determinations
  - "Gold carding" for physicians who meet certain criteria
  - AMA urged CMS to pause implementation, make participation voluntary, ensure guardrails for AI, increase transparency, and reduce administrative burden

Stay Connected

- AMA Medicare Physician Payment Schedule webpage
  - Summary of proposed rule

  - RUC infographic

- AMA Advocacy Update
  - Subscribe for weekly newsletter on key federal and state information
- Fix Medicare Now
  - Resources, grassroots campaigns to preserve patient access to care by passing inflation-based Medicare updates for physicians

- Ms. Hananoki addressed questions from attendees:
  - A RUC member inquired about the potential positive impact of HCPCS code G2211 on physicians who are reporting the service. Further, they asked whether there has been any research into what other payors are doing with the code. Ms. Hananoki responded that the AMA encourages specialty societies to go to the CPT Editorial Panel with a code change application if there is interest in receiving payment for these types of services across other payers. As far as qualitative data related to the impact of G2211 for physicians, we do not have that at this time but would welcome this type of feedback. It was also noted that the budget neutrality cut from G2211 harmed primary care physicians via the outsized conversion factor reduction. A prospective adjustment to correct for the inaccurate budget neutrality adjustment would help everyone, including the physicians who are currently reporting the code.

MPFS Spending and Utilization 2019-2025

Apoorva Rama, PhD, AMA Director of Economics, provided data on MPFS services, broad measures of MPFS spending and utilization, and select new codes during 2024-2025 Q1. Please see full presentation attached for more details.

- Medicare 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
  - Traditional Medicare enrollment was 34 million in 2023.
    - Declined by 11% from 2019 to 2023.
    - Compared to 41% growth in Medicare Private Plan enrollment.
  - Traditional Medicare made up 48% of Medicare Spending in 2023.
    - Compared to 61% in 2019.
  - MPFS made up 13% of Medicare Part B spending in 2024.
    - Compared to 20% in 2019.

- Claims Data
  - Individual claims data for a 5% sample of Medicare fee-for-service (FFS) beneficiaries
    - Quarterly data files are available through 2025 Q1.
    - These data reflect approximately a 93% completion rate.

- Note: Data based on claims for 100% of Medicare FFS beneficiaries will be available soon and used to update the RUC database through 2024.
- Results are scaled to reflect the Part B FFS population.

MPFS Spending and Utilization 2019 to 2025 Q1

- Dr. Rama discussed the following topics related to MPFS spending:
  - MPFS Spending Per Enrollee by Quarter
  - MPFS Spending by Type of Service
  - Evaluation and Management (E/M) Per Enrollee Spending and Utilization Growth (2019-2024)
  - Procedures/Therapy, Tests, Imaging (2019-2024)
  - MPFS Spending Per Enrollee Growth 2109-2024 by Place of Service
  - MPFS Spending Per Enrollee Growth 2019-2024 by Specialty
  - Nurse Practitioners (NPs) and Physician Assistants (PAs) Per Enrollee Spending and Utilization Growth (2019-2024)
  - Telehealth Spending as Share of MPFS Total
  - Decomposing the ~$2.4B Spent on Telehealth in 2024

Select New Codes 2024-2025 Q1

- G2211 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.
    - Introduced in 2024.
    - 2025: mod 25 allowed if there is also a separate, applicable AWV/Imm Code
  - 2024 Final Rule:
    - "G2211 will be billed with 38 percent of all O/O E/M visits"
    - "G2211 could be billed with 54 percent of all O/O E/M visits when fully adopted."
    - "the specific portion of the total budget neutrality adjustment attributable to the proposal to make payment for the O/O E/M inherent complexity add-on code to be approximately 2.00 percent"
  - 2024-2025 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.

- Dr. Rama addressed G2211 Utilization Relative to Office E/M by Month

- G2211 Utilization and Spending
  - CMS estimated G2211 utilization to be 3.4x the actual use in 2024.
  - This suggests a nearly $1 billion overestimate in spending in 2024.
  - G2211 utilization relative to Office E/M utilization is
    - 11.4% in 2024 compared to the estimated 38% in the final rule.
    - 17.0% in 2025 Q1 compared to the expectation of 54% when fully adopted.

- G2211 Conversion Factor Impact
  - The 2024 cut to the CF was ~1.5-2.5 larger than it should have been.

- G2211 Utilization by Specialty (2024-2025 Q1)
    - Family Medicine, 20%
    - Internal Medicine 18%
    - Nurse Practitioner, 12%
    - Cardiology 6%
    - Urology 6%
    - PA 5%
    - Hematology/Oncology 5%
    - Other 28%

- G2211 Utilization Relative to Office E/M by Specialty
    - G2211 utilization relative to eligible Office E/M utilization is 12.5% from 2024-2025 Q1. For specialties that utilized G2211 the most:
        - Family practice: 22%
            - For every 100 Office E/M services provided by a family practice physician, 22 of those services had G2211 added on.
        - Internal medicine: 20%
        - Nurse practitioner: 11%
        - Urology: 25%
        - Cardiology: 15%
        - Physician assistant: 8%

- G0556, G0557, G0558 Advanced Primary Care Management (APCM)
    - APCM services provide patients with a wide range of services to meet their individual needs based on complexity and are billed using a monthly bundle (not time-based).
    - New to 2025, CMS estimated 1.8M utilization for 2025.
    - 2025 Q1 Claims Data show:
        - ~260K utilization and ~$14M in allowed charges.
        - Utilization was 44% less than expected (compared to average per quarter)
        - Utilization by specialty: Nurse Practitioner (34%), Family Medicine (29%), Internal Medicine (23%), Emergency Medicine (9%)

- G0545
    - G0545 is the add-on code for billing specialized infectious disease E/M services during hospital inpatient or observation care (99221–99233).
    - New to 2025, CMS estimated 9K utilization for 2025.
    - 2025 Q1 Claims Data show:
        - ~325K utilization and $14M in allowed charges.
        - Utilization was almost 150x larger than expected (compared to average per quarter)
        - Utilization by specialty: 81% Infectious Disease (ID) and 11% Internal Medicine.
        - ID specialty billed G0545 with eligible hospital/observation E/M codes 26% of the time (i.e., for every 100 hospital/observation E/M visits, 26 of them had this add-on).

- Modifier 54
    - Mod 54: used to indicate only the surgical portion of the procedure was performed by the physician and there was a transfer of care during the global surgery period (for surgical care only).
        - New to 2025: Informal transfers of care are now required to use mod 54.
    - Q1 claims data
        - Only 2% different from the CMS estimate for 2025 (average per quarter)
        - Limited changes in 2025.
        - Ophthalmology are 85% of allowed charges in 2025 Q1 (87% in 2024 Q1).
        - Emergency medicine are 11% of allowed charges in 2025 Q1 (10% in 2024 Q1)
            - 14% per enrollee spending growth from 2024 Q1 to 2025 Q1.

- 75580, 92229 Artificial Intelligence
    - 75580 is noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography.
        - New to 2024, CMS estimated utilization to be 9K.
        - 2024 Quarterly Claims Data: 27K utilization and $9M in spending.
            - 47% of utilization was from Cardiology
        - 92229 is imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral.
            - New in 2021, CMS estimated utilization to be 1K in 2024.
            - 2024 Quarterly Claims Data: 5K utilization and $211K in spending.
                - From 2021 to 2024, per enrollee spending increased by 12x

<u>Wrap-up</u>
Quarterly Claims Data show:

- MPFS
    - Per enrollee spending increased by 15% (2019-2025 Q1)
    - E/M saw more growth compared to other type of service categories (2019-2024)
    - Skilled nursing facilities (SNF) and Offices saw more growth compared to other place of services (2019-2024)
    - NPs and PAs saw more growth compared to other specialties (2019-2024)
- G2211 (2024-2025 Q1): Utilization of this code is significantly less than expected, but still growing.

- Dr. Rama addressed questions from attendees:
    - A RUC member inquired about how Dr. Rama calculated the denominator for the HCPCS code G2211 utilization relative to Office E/M by month and if E/M visits with a Modifier 25 were excluded. The calculation is consistent with CMS's methodology, enabling direct comparison to the 38% of all office E/M visits relative utilization expectation published by CMS.
    - A RUC member inquired about the projected use of HCPCS code G2211 and if it will continue to increase or perhaps plateau before it reaches the CMS anticipated utilization. Dr. Rama responded that the data is trending upward but there is no way to know if that trend will continue or if a plateau will occur. She noted that in 1st quarter of 2025, G2211 utilization relative to Office E/M visits was 17% as compared to the CMS anticipated 54% when fully implemented.

- A RUC member stated that the HCPCS code G2211 data demonstrates relatively modest growth across the whole group, however, some specialties have doubled within that. The member suggested that a RAW screen could be implemented to better understand specialty growth within the reporting of G2211. Another member requested data the specialty associated with the nurse practitioner (NP) and physician associate (PA) claims related to G2211. Dr. Rama responded that at this time there is not any mechanism to split out NP and PA claims by "specialty".
- A RUC member mentioned that some Medicare Advantage plans do not pay for HCPCS code G2211 or pay so little that some institutions have been told not to report the code. Dr. Rama responded that this type of information to understand the real-world examples of how the code is being used is helpful.
- A RUC member inquired about Modifier 54, questioning if it was a result of education or if the applicable specialties truly had a transfer of care outside of their specialty. Dr. Rama responded that for ophthalmology specifically, there are two codes that have a typical transfer of care which has resulted in ophthalmology being the dominant specialty for Modifier 54. AMA RUC staff clarified that the codes relate to cataract surgery and this routine use of Modifier 54 precedes the CMS current discussion and policy.
- A RUC member inquired about progress to obtain the Medicare Advantage data. Separately, the member asked if the AMA had looked at the HCPCS codes for behavioral intervention, smoking cessation, and depression similar to the review of G2211. Dr. Rama responded that we are actively working on obtaining Medicaid and Medicare Advantage data and hope to be able to share an update soon. Further, the AMA has not done a similar analysis relative to G2211 for the codes mentioned. AMA staff clarified that the claims data for all these services will be included in the update to the RUC database, to be distributed in December.

IX. Relative Value Recommendations for CPT 2027

Ablation Therapy – Bone Tumors (Tab 4)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Adam Levin, MD (AAOS)

In February 2025, the CPT Editorial Panel approved new Category I add-on code 209XX to describe and report cryoablation during an open surgical procedure where the bone is frozen after a tumor resection. The physician work involves applying liquid nitrogen to the bone defect to freeze it. Typically, this open therapy is performed to address large or complex tumors rather than using percutaneous methods. CPT code 209XX was surveyed for the April 2025 meeting, and the specialty recommended an interim value with the intention to re-survey for the September 2025 RUC meeting. The RUC determined that the specialty society may survey CPT code 209XX with an amended ZZZ survey template that specifically asks respondents whether pre- and post-service time is associated with this add-on service for the September 2025 RUC meeting.

209XX ***Ablation therapy for reduction or eradication of bone tumor, including adjacent soft tissue when involved by tumor extension, cryoablation, open (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 31 orthopaedic surgeons who self-designate as musculoskeletal oncologists and recommends the survey 25th percentile work RVU of 2.70, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 25 minutes of intra-service time and 2 minutes of immediate post-service time, which equals 32 minutes of total time.

In their rationale, the specialty society clarified that 5 minutes of pre-service evaluation time is appropriate and typical for discussing the purpose of ablation therapy after tumor excision and describing the technical aspects of the procedure with the patient and/or family. This technique might be a preferred intervention compared to percutaneous cryoablation (CPT code 20983 *Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation*) for bone tumors in certain cases, particularly for large or complex tumors, because it allows for more precise and complete tumor destruction with better direct visualization and protection of neurovascular and soft tissue structures. The specialty society also confirmed that three 5-6-minute freeze-thaw cycles of cryoablation represent the typical physician work involved with this procedure.

To support the recommended work RVU of 2.70, the RUC compared the surveyed code to the top key reference service code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU = 2.50, 25 minutes intra-service time, 32 minutes total time) and second key reference service code 22515 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)* (work RVU = 4.00, 30 minutes intra-service time, 32 minutes total time). The RUC notes that together the two key reference services make for strong comparator codes, recognizing they bracket the survey 25th percentile work RVU of 2.70. The top key reference service requires 25 minutes of intra-service time, which is identical to the code surveyed. Moreover, both key reference services require 32 minutes of total time, which is the same total as CPT code 209XX. In terms of intensity/complexity, the RUC also acknowledges that CPT code 209XX is slightly more intense to perform than the top key reference service and slightly less intense to perform than the second key reference service. In their rationale, the specialty societies detailed that CPT code 209XX describes an ablation procedure that is more intense/complex than CPT code 20702 due to the need to meticulously protect the popliteal artery, tibial nerve, common peroneal nerve, and the surrounding skin, muscles, and tendons during the procedure, to which the RUC agreed. Thus, the RUC recommendation of the survey 25th percentile work RVU of 2.70 appropriately reflects the work and time required to perform CPT code 209XX, and also maintains relativity across comparable services. **The RUC recommends a work RVU of 2.70 for CPT code 209XX.**

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

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

Intraosseous Fiducial Marker Placement (Tab 5)
Minhajuddin Khaja, MD (SIR), Benjamin Northrup, MD (ACR)

In May 2025, the CPT Editorial Panel approved the addition of two codes and guidelines to report percutaneous intraosseous fiducial marker placement for the first target site and each additional target site, respectively. Intraosseous fiducial marker placement procedures involve image-guided placement of localization markers to facilitate safety, accuracy, and efficiency in future therapeutic interventions. The specialties clarified that these codes are not new technology but are new codes to more accurately describe existing technology.

209X1 ***Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site***
The RUC reviewed the survey results from 33 diagnostic radiologists and interventional radiologists and determined that the survey 25th percentile work RVU of 3.00 appropriately accounts for the physician work involved in this service. The RUC recommends 18 minutes pre-service evaluation time, 6 minutes positioning time, 6 minutes scrub/dress/wait time, 30 minutes intra-service time, 20 minutes immediate post-service time for 80 minutes total time, as supported by the survey.

The pre-service time matches the selected time package 2 *FAC Difficult Pat/Straightforward Procedure(no sedation/anes)* in the facility-setting. This includes 5 additional minutes for positioning time due to the prone setup of the patient within the CT bore, monitoring, lines, tubes, and equipment within a CT room and ensuring that all devices attached to the patient are able to clear and slide in and out of the CT gantry in order to maintain sterility and procedural success. Moreover, it was clarified that the physician is present for the entirety of the initial CT scan in the pre-service work. It is typical that the physician will help the CT technologist adjust the field of view, the extent of the scan, etc., as these are challenging patients and complex scans.

To justify a work RVU of 3.00, the RUC compared CPT code 209X1 to the to the top key reference service code 32408 *Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed* (work RVU = 3.18, 40 minutes intra-service time and 101 minutes total time) and to the second key reference service code 49406 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous* (work RVU = 4.00, 40 minutes intra-service time and 95 minutes total time) noting that the reference services involve more intra-service and total time than the surveyed code and are appropriately valued higher.

For additional support, the RUC compared the surveyed code with CPT code 33997 *Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion* (work RVU = 3.00, 30 minutes intra-service time and 75 minutes total time) which involves an equivalent amount of physician work, identical intra-service time, and similar total time.

The RUC noted that the survey 25th percentile value is appropriately bracketed by MPC codes 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU = 2.75 and 30 minutes intra-service time and 76 minutes total time) and 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU = 4.00 and 40 minutes intra-service time and 95 minutes total time). The RUC concluded that CPT code 209X1 should be valued at the 25th percentile

work RVU as supported by the survey. **The RUC recommends a work RVU of 3.00 for CPT code 209X1.**

209X2 ***Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site***
The RUC reviewed the survey results from 30 diagnostic radiologists and interventional radiologists and determined that the survey 25th percentile work RVU of 1.76 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 28 minutes of intra-service time as supported by the survey. It was clarified that the CT is repeated for the entire field of view for the add-on service; it must be repeated for each new localization to ensure accurate needle placement, especially in the case of patient movement. It was further clarified that the frequency of patients who would require the add-on service would be rare.

To justify a work RVU of 1.76, the RUC compared CPT code 209X2 to the top key reference service code 19082 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)* (work RVU = 1.65, 25 minutes intra-service time and 30 minutes total time) and noted that the intra-service time is greater for the surveyed code, justifying the higher work value. The RUC also compared CPT code 209X2 to the second key reference service code 64634 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)* (work RVU = 1.32, 20 minutes intra-service and total time) and noted that the reference service has less intra-service and total time and is appropriately valued lower than the surveyed code. Moreover, 100% of those survey respondents who selected the second top key reference code rated the surveyed code as more overall intense/complex relative to the key reference service. It was noted that the top key reference code is a much better comparison for marker placement, although it is in the soft tissues rather than within the bone, like the 209X2 code.

For additional support, the RUC compared the surveyed code to CPT code 36474 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 1.75, 30 minutes intra-service and total time) and noted the similar physician work, intra-service and total time. The surveyed code is slightly more intense and complex, justifying the slightly higher work value.

The RUC also noted that the surveyed code is appropriately bracketed by MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 20 minutes intra-service time and 21 minutes total time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 15 minutes intra-service and total time). The RUC concluded that CPT code 209X2 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.76 for CPT code 209X2.**

Practice Expense
For CPT code 209X1, the Practice Expense (PE) Subcommittee acknowledged that pre-service clinical activity time for 000- and 010-day global codes is presumed to be zero. The Subcommittee agreed with the specialties' use of the pre-service time package for "Extensive Use of Clinical Staff" in the non-facility for a 000-day global code and approved similar facility pre-service time. The specialty societies confirmed that use of CA006 *Confirm availability of prior images/studies* is typical, and the standard minutes for CA006 and CA007 *Review patient clinical extant information and questionnaire* were approved as recommended.

The specialties confirmed that moderate sedation is typical for these codes. Therefore, since the service is performed with moderate sedation, the PE Subcommittee ensured that duplicate PE inputs do not exist with those listed for the moderate sedation codes. There was discussion regarding EF027 *table, instrument, mobile,* and the specialty societies confirmed that this table is used to hold the sterile equipment for the procedure and is separate from the one used for moderate sedation.

In addition, the PE Subcommittee agreed with the various clinical staff types: L037D *RN/LPN/MT*, L041A *Vascular Interventional Technologist*, L046A *CT Technologist*, and L051A *RN*, as specified for performing the numerous clinical activities and confirmed that the vascular tech is only present for the intra-service period.

Two modifications were made to the supply inputs to remove SJ041 *povidone soln (Betadine*) and SK075 *skin marking pen, sterile (Skin Skribe)* from code 209X2. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Computer Assisted Surgical Navigation (Tab 6)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS)
In April 2024, the Relativity Assessment Workgroup (RAW) identified CPT code 20985 as part of the high-volume growth screen, with Medicare utilization over 10,000, which has increased by at least 100% from 2017 through 2022. Separately, codes 0054T and 0055T had been identified on the high-volume CPT Category III screen. The specialty society noted that codes 20985, 0054T, and 0055T represented the same service if minor changes were made in the 20985 code descriptor. In September 2024, the RAW reviewed the action plan for 20985 and recommended that the RUC refer CPT code 20985 to the CPT Editorial Panel for revision, to modify the descriptor and address overlap with codes 0054T and 0055T. At the February 2025 CPT Editorial Panel meeting, CPT code 20985 was revised to remove "image-less" for reporting computer-assisted surgical navigational procedures for musculoskeletal procedures. The two existing Category III codes will be deleted for CPT 2027.

CPT code 20985 was surveyed for the April 2025 meeting, and the specialty recommended an interim value with the intention to re-survey for the September 2025 RUC meeting. The RUC determined that the specialty society may survey CPT code 20985 with an amended ZZZ survey template that specifically asks respondents whether pre- and post-service time is associated with this add-on service for the September 2025 RUC meeting.

Based on parallel RAW review, CPT code 20985 and related family (eg, 20985 is reported with 27447 76% of the time) codes were identified for review at the April 2025 RUC meeting. The specialty societies indicated that CPT codes 20985, 27130, 27446 and 27447 were not a family of services as 20985 is an add-on code that can be reported with hundreds of different musculoskeletal procedures. The RUC noted that CPT code 20985 is reported 76 percent of the time with CPT code 27447. However, as CPT code 27447 has much more volume than 20985, only 18 percent of the

claims that have code 27447 also include code 20985. The other joint arthroplasty codes are also currently not typically reported with computer-assisted surgical navigation. For the April 2025 meeting, CPT codes 27130 and 27447 were separately identified in a RAW site of service anomaly screen for services that are typically outpatient, though still have inpatient visits. Due to this separate identification, all four services will be reviewed at the September 2025 meeting.

20985 ***Computer-assisted surgical navigational procedure for musculoskeletal procedures (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 78 orthopaedic surgeons and recommends a work RVU of 2.50, maintaining the current value. The RUC recommends 10 minutes pre-service time and 20 minutes intra-service time and 1 minutes of post-service time, totaling 31 minutes. The specialties noted and the RUC concurred that 10 minutes of pre-service time is typical to account for the additional time and effort required to initiate and calibrate computer navigation equipment, as well as additional patient positioning time for the computer navigation to be used. The specialties noted and the RUC concurred that 1 minute of post-service time is necessary to apply dressings to additional wounds related to the computer navigation pins/trackers and to review and sign off on intraoperative computer navigation imaging. The RUC confirmed that this pre-service and post-service time is distinct from the base musculoskeletal procedures that 20985 would be performed with.

The RUC compared the surveyed code to the top key reference code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service 25 minutes and total time 32 minutes) and determined that both services typically involve very similar total time and should be valued the same. Of the survey respondents who selected this key reference code, 77 percent indicated that the surveyed code is more intense than key reference code 20702. Also, both procedures involve additional pre-service and post-service surgeon work that is not part of the primary "skin-to-skin" procedure.

For additional support the RUC referenced CPT code 33268 *Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)* (work RVU= 2.50, 20 minutes intra-service and total time) and noted that both services involve the same amount of intra-service time, though the reference code is a more intense service to perform with less total time. **The RUC recommends a work RVU of 2.50 for CPT code 20985.**

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

<u>Sacroiliac Joint Arthrodesis Revision (Tab 7)</u>
Curtis Anderson, MD (OEIS), Minhajuddin Khaja, MD (SIR), Andrew Moriarity, MD (ACR), Clemens Schirmer, MD (AANS), Hussein Elkousey, MD (AAOS)

At the September 2024, the CPT Editorial Panel combined three code change applications (CCAs) to clarify the term “transfixation” through editorial changes to codes 27278 and 27279. In preparation for the January 2025 RUC meeting, the specialty societies delivered two separate letters to the RUC. In these letters, the specialty societies noted that the changes made by the CPT Editorial Panel to these codes are editorial and requested that neither be resurveyed for the January 2025 RUC meeting. The specialty societies requested affirmation by the RUC of the current value for both CPT codes

27278 and 27279, noting that the RUC will have an opportunity to review these codes as the result of a pending CPT CCA at the February 2025 CPT Editorial Panel meeting, which was brought forth independently by the specialty societies. The RUC noted it is well past the time for affirmation of 27279 in terms of when that service was last surveyed in April 2018. The RUC did not vote on affirmation for codes 27278 and 27279 and instead agreed to submit no recommendation.
CPT codes 27278 and 27279 were revised again at the May 2025 CPT Editorial Panel meeting. CPT code 27278 was revised to include imaging guidance, placement of intra-articular structural bone graft, metal, and/or synthetic device(s) without cortical piercing. CPT code 27279 was revised to include placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw(s), flange(s), blade(s)) piercing the lateral cortex of the sacrum and the medial cortex of the ilium. CPT codes 27278 and 27279 were surveyed for the September 2025 RUC meeting.

During the discussion at the RUC, it was noted that anesthesiology did not participate in the RUC survey for CPT code 27278. CY 2024 Medicare claims data obtained from the CY 2026 Proposed Rule show anesthesiology as the predominant specialty for CPT code 27278. The specialties submitted a letter that stated that the revised code descriptor does not shift the typical procedural work to justify resurvey. The letter further states that the code was effective for CPT 2024 and reevaluation would be premature at this time. CPT code 27278 was placed on the new technology/ new services list when it was reviewed for CPT 2024, and the Relativity Assessment Workgroup (RAW) will assess this service via that screen in April 2028. The RUC acknowledged the letter and stated that the specialties had the opportunity to survey and chose not to, therefore, cannot use a change in specialty as a compelling evidence argument in the future.

27278 ***Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of intra-articular structural bone graft, metal and/or synthetic device(s) without cortical piercing, including use of osteopromotive material and/or obtaining bone graft, when performed***
The RUC reviewed the survey results from 35 surgeons and recommends maintaining the current work RVU of 7.86, which preserves relativity within the family. The RUC recommends 33 minutes of pre-service evaluation time, 15 minutes positioning time, 15 minutes scrub/dress/wait time, 48 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238, 2-99213, totaling 196 minutes. The RUC agreed with the specialty recommendation that a half-day discharge visit and 2-99213 office visits are typical. The first post-operative office visit is two weeks post-surgery and involves wound assessment, confirmation of healing in the absence of infection, management of pain, and placement of imaging or physical therapy orders. The second post-operative office visit is around 6 weeks post-surgery and includes imaging to evaluate healing, ensuring proper fusion, continuation of pain and medication management, and updates to the care plan and related physical therapy needs.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference codes 22869 *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level* (work RVU = 7.03, 45 minutes intra-service, and 175 minutes total time) and 22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level* (work RVU = 15.00, 90 minutes intra-service, and 271 minutes total time). The surveyed code work RVU is appropriately bracketed by the intra-service time and total time of both key reference codes. However, the surveyed code falls closer to the top key reference code 22869, although the surveyed code is valued slightly higher, which reflects a marginally longer intraoperative time and slightly greater post-service work.

The RUC recognizes that CPT code 22869 is a strong point of comparison to the survey code in terms of intra-service time, total time and intensity.

For additional support, the RUC also referenced CPT code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU= 7.39, 45 minutes intra-service time, 199 minutes total time) and noted that the surveyed code is a somewhat more intense and complex procedure to perform and would have appropriate relativity with this reference service. Therefore, the recommendation to maintain the work RVU of 7.86 for CPT 27278 is well supported by the relativity of other codes in the MFS. **The RUC recommends a work RVU of 7.86 for CPT code 27278.**

27279 ***Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw[s], flange[s], blade[s]) piercing the lateral cortex of the sacrum and the medial cortex of the ilium (with or without piercing the lateral cortex of the ilium), including use of osteopromotive material and/or obtaining bone graft, when performed***
The RUC reviewed the survey results from 53 surgeons and recommends a work RVU of 11.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 33 minutes of pre-service evaluation time, 15 minutes positioning time, 14 minutes scrub/dress/wait time, 60 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238, 2-99213, 1-99212, totaling 223 minutes. The RUC agreed with the specialty recommendation that a half-day discharge visit and 2-99213 and 1-99212 office visits are typical. The post-operative office visits involve wound assessment, confirmation of healing in the absence of infection, management of pain, and placement of imaging or physical therapy orders. Further, follow-up imaging is necessary to evaluate healing and to ensure proper fusion. Lastly, continuation of pain and medication management, updates to the care plan, and related physical therapy needs as assessed at each visit.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference service codes 22867 *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level* (work RVU = 15.00, 90 minutes intra-service, and 271 minutes total time) and 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* (work RVU = 10.92, 90 minutes intra-service, and 254 minutes total time). Survey respondents indicated that the surveyed code was identical, somewhat more, or much more intense/complex when compared to the first key reference service code 22867. Survey respondents indicated that the surveyed code was identical or somewhat more complex when compared to the second key reference code 63655. The surveyed code intra-service time and total time are lower than the reference codes; however, the survey respondents indicated that the overall intensity/complexity of the surveyed code is very similar to the first key reference code 22867 and somewhat more than the second key reference code 63655. Therefore, the survey code recommended work RVU is appropriately supported by the key reference services.

For additional support, the RUC referenced code 63662 *Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed* (work RVU = 11.00, 60 minutes intra-service, and 243 minutes total time). The codes have identical intra-service time, similar post-operative work, and similar total time and therefore, should be valued similarly. **The RUC recommends a work RVU of 11.00 for CPT code 27279.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for CPT codes 27278 and 27279 and made two adjustments to account for the use of moderate sedation. Since these services are performed with moderate sedation, the PE Subcommittee ensured that duplicate PE inputs do not exist with those listed for the moderate sedation codes. Therefore, the supply input SA054 *pack, post-op incision care (suture)* and the equipment item EQ032 *IV infusion pump* were removed to eliminate any duplication.

In addition, the PE Subcommittee discussed existing high-cost disposable supply item, SD356 *Dorsal SI Joint Arthrodesis Implant,* for CPT code 27278 noting that the specialties submitted an invoice to support a price increase from $11,500 to $12,500. Further, the PE Subcommittee acknowledged the new high-cost supply input, *Dorsal SI joint articular fixation device,* as recommended for CPT code 27279. **The RUC continues to call on CMS to separately identify and pay for high-cost disposable supplies using appropriate HCPCS codes.**

The Subcommittee also noted the appropriate Use of Clinical Staff pre-service standard time package for 090-day globals in the non-facility and facility. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

<u>Cardiac Contractility Modulation (Tab 8)</u>
Mark Schoenfeld, MD (HRS), Ed Tuohy, MD (ACC), Richard Wright, MD (ACC)

In May 2025, the CPT Editorial Panel approved a new family of 11 Category I CPT codes for insertion, removal, and replacement of cardiac contractility modulation (CCM) systems, generators, and leads in several combinations. A separate set of four codes was created to describe the corresponding CCM programming, interrogation, and remote interrogation services. All 11 of the insertion, removal, and replacement/repositioning/revision CCM codes, as well as three programming, interrogation, and remote interrogation CCM services that involve physician work, were surveyed for the September 2025 RUC meeting.

CCM is an implantable device-based therapy for heart failure with reduced ejection fraction that delivers non-excitatory biphasic electrical signals to the right ventricular septal wall during the heart's absolute refractory period. This therapy does not initiate a new cardiac depolarization or a contraction but enhances cardiac contractility with improved calcium handling and calcium-induced release from the cellular sarcoplasmic reticulum. CCM therapy is intended for patients with moderate to severe heart failure symptoms to improve their quality of life and reverse cardiac remodeling. 80% of patients who undergo CCM have concomitant devices, such as defibrillators or pacemakers, making these CCM services more complex and intense. The current technology employs transvenous implantation of two ventricular leads, actively fixated to the right ventricular septum, spaced roughly 2 centimeters apart, connected to a generator that is a unit that requires recharging on a weekly basis. Intraoperative assessment entails adequate positioning, sensing thresholds, capturing thresholds to assure stability to stimulate, ruling out extracardiac pain through stimulation of intercostal musculature, and ruling out electromagnetic interference with already present devices.

CCM Code Family
The specialty societies detailed the four code subsets within the CCM code family, which include CCM insertion services (33X01-33X04), CCM removal services (33X05-33X08), CCM replacement, repositioning, and revision services (33X09-33X11), and CCM programming, interrogation, and

remote interrogation services (93X01-93X03). The RUC discussed the relative value of physician work across all services within this code family, determining that the CCM removal services typically require more physician work than their corresponding CCM insertion services. Moreover, CCM replacement, repositioning, and revision services require less physician work than both removal and insertion services, followed by CCM programming, interrogation, and remote interrogation services, which require considerably less time than the 11 surgical CCM services. The RUC agreed with the described relativity and the subsequent rank order between these services.

Comparison to Permanent Pacemaker Pulse Generator Procedures
Many of the key reference services selected by the survey respondents compared the CCM surgical codes and programming/interrogation codes to analogous permanent pacemaker pulse generator surgical, programming and interrogation codes. In contrast to a pacemaker, which modulates the heart's rhythm, the cardiac contractility modulation system's impulses are designed to modulate the strength of contraction of the heart muscle. Unlike pacemakers, these systems stimulate for specific time intervals to improve myocardial function. Stimulation from a CCM device is considered non-excitatory, meaning it does not induce a heartbeat. CCM signals are delivered using a sophisticated timing algorithm during the heart's absolute refractory period. Rather than induce a contraction, CCM signals create changes at the cellular level to increase contractile strength of the heart.

For the CCM surgical procedure codes, the specialties noted that there is a substantial difference in the type of leads the EP cardiologist or electrophysiologist is working with and how they place them relative to the pacemaker insertion/removal procedures. One right ventricular lead is placed on the high septum and a second lead is placed in the mid-septum. These are two leads in the ventricle that are specifically located on the ventricular septum within a certain distance that has to be tested with one another so they can interact, because the timing of those two leads is critical in delivering the non-excitatory impulse during the absolute refractory period. Placement of CCM leads requires more skill relative to the placement of pacemaker leads, where positioning was less critical. An additional lead may also be placed in the right atrial appendage, though an atrial lead is used in an extreme minority of cases. Each lead for CCM has a helical coil fixation, whereas many other types of ventricular leads are passive fixation tines that enter into the trabeculum of the right ventricle, which have no ability to place them anywhere else aside from the apex of the heart.

Insertion of Permanent CCM System
In reviewing this subset of services within the CCM code family, the RUC determined the rank order for the CCM surgical insertion services is as follows: CPT code 33X01 (insertion of the entire CCM system); CPT code 33X04 (insertion of dual transvenous electrode); CPT code 33X03 (insertion of a single transvenous electrode); and CPT code 33X02 (insertion of pulse generator), respectively. The post-operative office visit is necessary for assessing the wound to see if it is healing appropriately, removing the dressing, and prescribing any required antibiotics or analgesic medications. Moreover, the RUC notes that for the four CCM insertion codes, the pre-service scrub/dress/wait time and immediate post-service time were adjusted as necessary to align with the survey results.

33X01 ***Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator and transvenous electrodes***
The RUC reviewed survey results from 51 electrophysiologists and heart failure specialists and recommends the survey 25th percentile work RVU of 8.83, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service

scrub/dress/wait time, 90 minutes of intra-service time, 20 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 210 minutes of total time.

The physician work involved with CPT code 33X01 describes insertion of the entire CCM system, which includes the pulse generator, the appropriate number of transvenous electrodes as determined by the physician prior to the procedure (either two right ventricular leads only or two right ventricular leads and a right atrial lead, depending on the patient), as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other insertion codes, 33X01 requires the most physician time and work since it involves the insertion of every implantable CCM component. Furthermore, the specialty societies anticipate that this service will be the most frequently performed of this code family.

To support the recommended work RVU of 8.83, the RUC compared the surveyed code to the top key reference service 33208 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular* (work RVU = 8.52, 60 minutes intra-service time, 231 minutes total time) and second key reference service 33217 *Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator* (work RVU = 5.59, 120 minutes intra-service time, 262 minutes total time). The RUC acknowledges that the surveyed code requires a similar amount of physician work compared to the top key reference service and significantly more physician work than the second key reference service. The RUC recognizes that together the top two key reference services selected by survey respondents bracket CPT code 33X01 in terms of intra-service time. Despite requiring less total time overall than the two key reference services, the RUC also notes that the surveyed code is slightly more intense/complex than the top key reference service and significantly more intense/complex than the second key reference service. Thus, comparison between these services is appropriate and relativity is maintained based on the physician work involved with these services.

For additional support, the RUC compared the surveyed code to MPC code 14040 *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less* (work RVU = 8.60, 90 minutes intra-service time, 223 minutes total time). The RUC notes that this reference requires 90 minutes of intra-service time, which is identical to the surveyed code, and while it requires slightly more time, 33X01 is a more intense/complex service to perform. Overall, the RUC recommendation of the 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 8.83 for CPT code 3XX01.**

33X02 ***Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator and transvenous electrodes; pulse generator only***
The RUC reviewed survey results from 39 electrophysiologists and heart failure specialists and recommends a work RVU of 5.80 based on a direct crosswalk to CPT code 33240 *Insertion of implantable defibrillator pulse generator only; with existing single* lead (work RVU = 5.80, 45 minutes intra-service time, 135 minutes total time) to appropriately account for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 40 minutes of intra-service time, 16 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 156 minutes of total time.

The physician work involved with CPT code 33X02 describes insertion of the pulse generator, as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other insertion codes, 33X02 requires the least physician time and work since it only involves the insertion of the pulse generator and not the insertion of a single or dual transvenous electrode(s). The specialty societies anticipate that this service will be performed infrequently, less than 33X01 and similarly to 33X03 and 33X04.

The RUC recognizes that the top key reference service 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU = 6.05, 45 minutes intra-service time, 181 minutes total time) requires similar intra-service time and more total time than the surveyed code. Moreover, the second key reference service 33208 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular* (work RVU = 8.52, 60 minutes intra-service time, 231 minutes total time) requires significantly more intra-service and total time than the surveyed code. To support the recommended value, the RUC found crosswalk CPT code 33240 to be a more appropriate service to compare to CPT code 33X02 in terms of intra-service time, total time, and overall measured intensity/complexity compared to the key reference services selected by survey respondents.

For additional support, the RUC compared the surveyed code to CPT code 67924 *Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)* (work RVU = 5.93, 40 minutes intra-service time, 149 minutes total time) and CPT code 46948 *Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed* (work RVU = 5.57, 40 minutes intra-service time, 163 minutes total time). Together, these two comparator codes bracket the RUC recommended work RVU of 5.80 percentile work RVU, and both codes require 40 minutes of intra-service time, which is identical to the surveyed code. While both of these comparator codes require more total time, both services are slightly less intense/complex to perform than CPT code 33X02, which is reasonable based on the differences in work and time between these procedures. Overall, the RUC's direct crosswalk recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 5.80 for CPT code 33X02.**

33X03 ***Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator and transvenous electrodes; transvenous electrode, single***
The RUC reviewed survey results from 40 electrophysiologists and heart failure specialists and recommends the survey 25th percentile work RVU of 6.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 50 minutes of intra-service time, 17 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 167 minutes of total time.

The physician work involved with CPT code 33X03 describes insertion of a single transvenous electrode, as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other insertion codes, 33X03 requires less physician time and work than CPT codes 33X01 and 33X04, but more than 33X02, since it does not involve the insertion of a dual transvenous

electrode or the pulse generator. The specialty societies anticipate that this service will be performed infrequently, less than 33X01 and similar to 33X02 and 33X04.

To support the recommended work RVU of 6.00, the RUC compared the surveyed code to MPC code 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, 45 minutes intra-service time, 161 minutes total time). Overall, the RUC recommendation of the 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 6.00 for CPT code 33X03.**

33X04 ***Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator and transvenous electrodes; transvenous electrode, dual***
The RUC reviewed survey results from 39 electrophysiologists and heart failure specialists and recommends the survey 25th percentile work RVU of 6.23, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 20 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 180 minutes of total time.

The physician work involved with CPT code 33X04 describes insertion of a dual transvenous electrode, as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other insertion codes, 33X04 requires less physician time and work than CPT codes 33X01, but more than 33X02 and 33X03, since it involves the insertion of a dual (not a single) transvenous electrode and does not include insertion of the pulse generator. The specialty societies anticipate that this service will be performed infrequently, less than 33X01 and similar to 33X02 and 33X04.

To support the recommended work RVU of 6.23, the RUC compared the surveyed code to the key reference service 33208 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular* (work RVU = 8.52, 60 minutes intra-service time, 231 minutes total time). For additional support, the RUC compared the surveyed code to MPC code 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)* (work RVU = 6.55, 60 minutes intra-service time, 222 minutes total time). The RUC notes this service requires the same amount of intra-service time as the surveyed code, and despite it requiring more total time overall, CPT code 33X04 is more intense/complex to perform. Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 6.23 for CPT code 3XX04.**

Removal of Permanent CCM System
In reviewing this subset of services within the CCM code family, the RUC determined the rank order for the CCM removal services is as follows: CPT code 33X04 (removal of the entire CCM system); CPT code 33X08 (removal of dual transvenous electrode); CPT code 33X07 (removal of single electrode); and CPT code 33X06 (removal of pulse generator), respectively. Compared to the CCM insertion services and CCM replacement/repositioning/revision services, the CCM removal services

typically require more time and involve more physician work, as the transvenous electrodes need to be located and entanglements have to be navigated carefully to mitigate the risk of bleeding. Of all the CCM insertion and removal services, removing just the pulse generator (CPT code 33X06) requires the least amount of physician work and time since it is the least risky and complicated to perform. The post-operative office visit is necessary for assessing the wound to see if it is healing appropriately, removing the dressing, and prescribing any required antibiotics or analgesic medications. Moreover, the RUC notes that for the four CCM removal codes, the pre-service evaluation time, pre-service scrub/dress/wait time, and immediate post-service time were adjusted as necessary in order to align with the survey results.

33X05 ***Removal of permanent cardiac contractility modulation system; pulse generator and transvenous electrodes***
The RUC reviewed survey results from 39 electrophysiologists and heart failure specialists and recommends the survey 25th percentile work RVU of 9.90, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 114 minutes of intra-service time, 40 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 254 minutes of total time.

The physician work involved with CPT code 33X05 describes removal of the entire CCM system, which includes the pulse generator, the appropriate number of transvenous electrodes as determined by the physician prior to the procedure (either two right ventricular leads only or two right ventricular leads and a right atrial lead, depending on the patient), as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other removal codes, 33X05 requires the most physician time and work since it involves the removal of every implantable CCM component. Furthermore, the specialty societies anticipate that this service will be the most frequently performed of this code family.

The survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty societies added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of the procedure, increasing it from the survey median of 20 minutes to 40 minutes (7 minutes above the selected time package). The RUC agreed with this allocation of post-service time based on the conventions of the 23-Hour policy.

To support the recommended work RVU of 9.90, the RUC compared the surveyed code to CPT code 14021 *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm* (work RVU = 9.72, 116 minutes intra-service time, 288 minutes total time) to support the RUC recommended work RVU of 9.90. The RUC notes that both services require nearly an identical amount of intra-service time. The RUC acknowledges that while the surveyed code requires less total time than 14021, it is a more intense/complex procedure to perform overall compared to the reference code. Comparison between these services is reasonable despite differences in total time, and the RUC notes that it is appropriate that CPT code 33X05 has a slightly greater work RVU than CPT code 14021. Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within

this code family and across comparable services. **The RUC recommends a work RVU of 9.90 for CPT code 33X05.**

33X06 ***Removal of permanent cardiac contractility modulation system; pulse generator and transvenous electrodes; pulse generator only***
The RUC reviewed survey results from 40 electrophysiologists and heart failure specialists and recommends a work RVU of 4.91 based on a direct crosswalk to CPT code 21040 *Excision of benign tumor or cyst of mandible, by enucleation and/or curettage* (work RVU = 4.91, 37 minutes intra-service time, 137 minutes total time) to appropriately account for the physician work typically required to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 38 minutes of intra-service time, 18 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 151 minutes of total time.

The physician work involved with CPT code 33X06 describes the removal of the pulse generator, as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other removal codes, 33X06 requires the least physician time and work since it only involves the removal of the pulse generator and not the removal of a single or dual transvenous electrode(s). The specialty societies anticipate that this service will be performed infrequently, less than 33X01, and similar to some of the other insertion codes.

To support the recommended work RVU of 4.91, the RUC compared the surveyed code to the second key reference service 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU = 6.05, 45 minutes intra-service time, 181 minutes total time). To support the recommended value, the RUC found crosswalk CPT code 21040 to be a more appropriate service to compare to CPT code 33X06 in terms of intra-service time and measured intensity/complexity compared to the second key reference service selected by survey respondents.

For additional support, the RUC compared the surveyed code to CPT code 21030 *Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage* (work RVU = 4.91, 33 minutes intra-service time, 133 minutes total time). The RUC notes that both the reference CPT code and surveyed code have the same work RVU and require nearly identical intra-service time and similar total time. Additionally, both services require similar intensity/complexity to perform. Overall, the RUC's direct crosswalk recommendation appropriately reflects the physician work and time required to perform this service and maintain relativity within this code family and across comparable services. **The RUC recommends a work RVU of 4.91 for CPT code 33X06.**

33X07 ***Removal of permanent cardiac contractility modulation system; pulse generator and transvenous electrodes; transvenous electrode, single***
The RUC reviewed survey results from 36 electrophysiologists and heart failure specialists and recommends a work RVU of 7.49 based on a direct crosswalk to CPT code 11970 *Replacement of tissue expander with permanent implant* (work RVU = 7.49, 60 minutes intra-service time, 216 minutes total time), to appropriately account for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 62 minutes of intra-service time, 40 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 202 minutes of total time.

The physician work involved with CPT code 33X07 describes the removal of a single transvenous electrode, as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other removal codes, 33X03 requires less physician time and work than CPT codes 33X05 and 33X08, but more than 33X06, since it does not involve the removal of a dual transvenous electrode or the pulse generator. The specialty societies anticipate that this service will be performed infrequently, less than 33X01, and similar to some of the other insertion codes.

The survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty societies added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of the procedure, increasing it from the survey median of 20 minutes to 40 minutes (7 minutes above the selected time package). The RUC agreed with this allocation of post-service time based on the conventions of the 23-Hour policy.

The RUC found crosswalk CPT code 11970 to be a more appropriate service compared to CPT code 33X07 in terms of intra-service time, total time, and overall measured intensity/complexity compared to the key reference services selected by survey respondents. To support the recommended work RVU of 7.49, the RUC compared the surveyed code to MPC code 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, 214 minutes total time). For additional support, the RUC also referenced MPC code 21556 *Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 7.66, 60 minutes intra-service time, 234 minutes total time). The RUC recognizes that together the two MPC comparator codes bracket the RUC recommended work RVU of 7.49 for CPT code 33X07. Overall, the direct crosswalk recommendation appropriately reflects the physician work and time required to perform this service and maintain relativity within this code family and across comparable services. **The RUC recommends a work RVU of 7.49 for CPT code 33X07.**

33X08 ***Removal of permanent cardiac contractility modulation system; pulse generator and transvenous electrodes; transvenous electrode, dual***
The RUC reviewed survey results from 38 electrophysiologists and heart failure specialists and recommends a work RVU of 8.60 based on a direct crosswalk to CPT code 14040 *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less* (work RVU = 8.60, 90 minutes intra-service time, 223 minutes total time) to appropriately account for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time, 40 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visits, which equals 230 minutes of total time.

The physician work involved with CPT code 33X08 describes the removal of a dual transvenous electrode, as well as fluoroscopic guidance and programming of sensing and therapeutic parameters. Compared to the other removal codes, 33X04 requires less physician time and work than CPT codes 33X01, but more than 33X02 and 33X03, since it involves the removal of a dual (not a single) transvenous electrode and does not include removal of the pulse generator. The specialty societies anticipate that this service will be performed infrequently, less than 33X01, and similar to some of the other insertion codes.

The survey results indicate that this procedure is typically performed in a hospital setting, that patients were not typically discharged on the same day as the procedure, and that a 23-hour stay (less than 24 hours) with a subsequent hospital visit is typical. Per the 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy, the specialty societies added 20 minutes of intra-service time from CPT code 99232 to the immediate post-service time of the procedure, increasing it from the survey median of 20 minutes to 40 minutes (7 minutes above the selected time package). The RUC agreed with this allocation of post-service time based on the conventions of the 23-Hour policy.

To support the recommended work RVU of 8.60, the RUC compared the surveyed code to CPT code 64568 *Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* (work RVU = 9.00, 90 minutes intra-service time, 275 minutes total time). For additional support, the RUC compared the surveyed code to CPT code 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (work RVU = 8.88, 90 minutes intra-service time, 207 minutes total time).

Additionally, the RUC acknowledges that the direct crosswalk code 14040 is on the MPC list. Overall, the RUC's direct crosswalk recommendation appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 8.60 for CPT code 33X08.**

Replacement, Repositioning, and Revision of Permanent CCM System

In reviewing this subset of services within the CCM code family, the RUC determined the rank order for the CCM replacement, repositioning, and revision services is as follows: CPT code 33X09 (removal and replacement of pulse generator); CPT code 33X11 (relocation or revision of skin pocket for pulse generator); and CPT code 33X10 (repositioning of transvenous electrode(s)), respectively. Compared to the CCM insertion services and CCM removal services, the CCM replacement/repositioning/revision services typically require less time and involve less physician work overall. Aside from implanting and removing just the pulse generator (CPT codes 33X02 and 33X06), this subset of services is less risky and complicated to perform than the CCM insertion and removal services. The post-operative office visit is necessary for assessing the wound to see if it is healing appropriately, removing the dressing, and prescribing any required antibiotics or analgesic medications. Moreover, the RUC notes that for the four CCM replacement/repositioning/revision codes, the pre-service evaluation time, pre-service scrub/dress/wait time, and immediate post-service time were adjusted as necessary in order to align with the survey results.

33X09 ***Removal and replacement of permanent cardiac contractility modulation system, pulse generator only***

The RUC reviewed survey results from 41 electrophysiologists and heart failure specialists and recommends the survey 25th percentile work RVU of 6.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 39 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 18 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 162 minutes of total time. The post-operative office visit is necessary for assessing the wound to see if it is healing appropriately, removing the dressing, and prescribing any required antibiotics or analgesic medications.

The physician work involved with CPT code 33X09 describes the removal and replacement of just the pulse generator in the CCM system. Compared to the other replacement/repositioning/revision codes, 33X09 requires more physician time and work since it involves removing and replacing the pulse generator, not just relocating/revising the existing pulse generator or repositioning a transvenous electrode. The specialty societies anticipate that this service will be performed infrequently, less than 33X01, and similar to some of the other insertion codes.

To support the recommended work RVU of 6.00, the RUC compared the surveyed code to the top key reference service 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU = 6.05, 45 minutes intra-service time, 181 minutes total time). For additional support, the RUC compared the surveyed code to MPC code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU = 5.93, 33 minutes intra-service time, 142 minutes total time) and MPC code 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)* (work RVU = 6.55, 60 minutes intra-service time, 222 minutes total time). The RUC notes that together these two services bracket the RUC-recommended survey 25th percentile work RVU of 6.00, as well as the intra-service and total time. Both reference codes also bracket the surveyed code in measured intensity/complexity. Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 6.00 for CPT code 33X09.**

33X10 ***Repositioning of previously implanted cardiac contractility modulation transvenous electrode(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters***

The RUC reviewed survey results from 42 electrophysiologists and heart failure specialists and recommends the survey 25th percentile work RVU of 5.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 37 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 18 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visits, which equals 175 minutes of total time. The post-operative office visit is necessary for assessing the wound to see if it is healing appropriately, removing the dressing, and prescribing any required antibiotics or analgesic medications.

The physician work involved with CPT code 33X10 describes repositioning a previously implanted CCM transvenous electrode. Compared to the other replacement/repositioning/revision codes, 33X10 requires less physician work overall compared to 33X09 and more than 33X11, since repositioning electrodes is more involved than revising the skin pocket but less so than removing and replacing the pulse generator. The specialty societies anticipate that this service will be performed infrequently, less than 33X01, and similar to some of the other insertion codes.

To support the recommended work RVU of 5.00, the RUC compared the surveyed code to the top key reference service 33215 *Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode* (work RVU = 4.92, 60 minutes intra-service time, 179 minutes total time). For additional support, the RUC compared the surveyed code to MPC code 63661 *Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* (work RVU = 5.08, 55 minutes intra-service time, 165

minutes total time). Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 5.00 for CPT code 33X10.**

33X11 ***Relocation or revision of skin pocket for implanted cardiac contractility modulation pulse generator***
The RUC reviewed survey results from 42 electrophysiologists and heart failure specialists and recommends a work RVU of 5.25 based on a direct crosswalk to CPT code 33227 *Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system* (work RVU = 5.25, 45 minutes intra-service time, 124 minutes total time) to appropriately account for the physician work typically required to perform this service. The RUC recommends 37 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 18 minutes of immediate post-service time, 0.5-99238 discharge visit and 1-99213 post-operative office visit, which equals 160 minutes of total time. The post-operative office visit is necessary for assessing the wound to see if it is healing appropriately, removing the dressing, and prescribing any required antibiotics or analgesic medications.

The physician work involved with CPT code 33X11 describes relocating/revising the skin pocket for the implanted CCM pulse generator. Compared to the other replacement/repositioning/revision codes, 33X11 requires less physician work overall, since removing and replacing the pulse generator and relocating electrodes requires more work to perform. The specialty societies anticipate that this service will be performed infrequently, less than 33X01, and similar to some of the other insertion codes.

To support the recommended work RVU of 5.25, the RUC compared the surveyed code to MPC code 33213 *Insertion of pacemaker pulse generator only; with existing dual leads* (work RVU = 5.28, 46 minutes intra-service time, 125 minutes total time) and MPC code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* (work RVU = 5.42, 45 minutes intra-service time, 151 minutes total time). Overall, the RUC's direct crosswalk recommendation appropriately reflects the physician work and time required to perform this service and maintain relativity within this code family and across comparable services. **The RUC recommends a work RVU of 5.25 for CPT code 33X11.**

Cardiac Contractility Modulation Programming, Interrogation, and Remote Interrogation Services
In reviewing this subset of services within the CCM code family, the RUC determined the rank order for the CCM programming, interrogation, and remote interrogation services is as follows: CPT code 93X01 (programming CCM system in person); CPT code 93X02 (interrogation device evaluation in person); and CPT code 93X03 (interrogation device evaluation remote), respectively. Compared to the CCM insertion, removal, and replacement/repositioning/revision services, these services typically require significantly less time and involve less physician work overall.

93X01 ***Programming of the cardiac contractility modulation system (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report by a physician or other qualified health care professional***
The RUC reviewed survey results from 47 cardiologists and recommends the survey 25th percentile work RVU of 0.90, which appropriately accounts for the physician work typically required to perform

this service. The RUC recommends 6 minutes pre-service evaluation time, 15 minutes intra-service time and 8 minutes immediate post-service time, which equals 29 minutes of total time.

To support the recommended work RVU of 0.90, the RUC compared the surveyed code to the top key reference service 93281 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system* (work RVU = 0.85, 15 minutes intra-service time, 32 minutes total time).

For additional support, the RUC compared the surveyed code to MPC code 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.90, 15 minutes intra-service time, 22 minutes total time) and MPC code 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.* (work RVU = 0.93, 15 minutes intra-service time, 20 minutes total time). Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 0.90 work CPT code 93X01.**

93X02 ***Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation system***
The RUC reviewed survey results from 47 cardiologists and recommends the survey 25th percentile work RVU 0.80, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 6 minutes pre-service evaluation time, 15 minutes intra-service time and 7 minutes immediate post-service time, which equals 28 minutes of total time.

Compared to CPT code 93X01, which describes programming the CCM system, CPT code 93X02, which describes interrogation of information collected by the CCM system, requires less physician work. The initial programming of the CCM system for 93X01 involves a more detailed analysis of the CCM data, and additional measurements and parameters are taken and assessed to see that the device is functioning properly. For 93X02, the physician reviews how the CCM is functioning based on the current programmed parameters.

To support the recommended work RVU of 0.80, the RUC compared the surveyed code to the top key reference service 93280 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system* (work RVU = 0.77, 15 minutes intra-service time, 32 minutes total time) and second key reference service 93281 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system* (work RVU = 0.85, 15 minutes intra-service time, 32 minutes total time).

For additional support, the RUC compared the surveyed code to MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81, 11 minutes intra-service time, 21 minutes total time) and 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, 20 minutes intra-service time, 26 minutes total time). Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform this service and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 0.80 for CPT code 93X02.**

93X03 ***Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, with interim analysis, review, and report(s) by a physician or other qualified health care professional***

The RUC reviewed survey results from 44 cardiologists and recommends a work RVU of 0.60 based on a direct crosswalk to CPT code 93294 *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU = 0.60, 10 minutes intra-service time, 20 minutes total time) to appropriately account for the physician work typically required to perform this service. The RUC recommends 5 minutes pre-service evaluation time, 11 minutes intra-service time and 5 minutes immediate post-service time, which equals 21 minutes of total time.

Compared to CPT code 93X01 and 93X03, CPT code 93X03, which describes remote interrogation of information collected by the CCM system, requires less physician work. Compared to the initial programming involved with 93X01 and the in-person interrogation involved with 93X02, the remote interrogation involves the physician assessing the same measurements and parameters but over the course of less intra-service and total time, thus justifying a lower work RVU.

To support the recommended work RVU of 0.60, the RUC compared the surveyed code to CPT 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56, 10 minutes intra-service time, 18 minutes total time). For additional support, the RUC compared the surveyed code to MPC code 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60, 10 minutes intra-service time, 16 minutes total time). The RUC acknowledges that this service has an identical work RVU and requires identical intra-service time as the surveyed code. Overall, the RUC's direct crosswalk recommendation appropriately reflects the physician work and time required to perform this service and maintain relativity within this code family and across comparable services. **The RUC recommends a work RVU of 0.60 for CPT code 93X03.**

Flawed Vignette

In a letter presented to the RUC, the specialty societies communicated that a flaw in the vignette for CPT code 93X03 was discovered, which describes the physician work of interpreting data collected remotely from the prior 90-day period. The specialty societies explained that the CCM device is not programmed remotely, nor does it have the ability to be. The use of the word "programming" rather than "interrogation" was an error in the original coding change application and was not caught until the conclusion of the survey. Essentially, CPT code 93X03 should have the same vignette as CPT code 93X04, which is a technical code for remote interrogation. The RUC recommended a direct crosswalk to a comparable interrogation device evaluation code to appropriately account for the

physician work typically required to perform this service and maintain relativity within this code family and across comparable services.

Practice Expense
The PE Subcommittee reviewed the direct practice expense inputs and made several modifications to the inputs for the XXX global codes 93X01-93X04. The Subcommittee removed the clinical staff time for CA009 *Greet patient, provide gowning, ensure appropriate medical records are available*, CA010 *Obtain vital signs*, CA011 *Provide education/obtain consent*, and CA027 *Complete post-procedure diagnostic forms, lab and x-ray requisitions* from CPT codes 93X01 and 93X02 to avoid duplication with other interrogation/programming codes, such as CPT codes 93284 and 93289. Similarly, the PE Subcommittee removed SA048 *pack, minimum multi-specialty visit* from 93X01 and 93X02 due to overlap with other interrogation/programming codes. In addition, the PE Subcommittee, and the specialties discussed who typically performs the intra-service of the service period work and agreed to change the clinical staff type for CA021 *Perform procedure/service---NOT directly related to physician work time* from L037D *RN/LPN/MTA* blend to L037A *Electrodiagnostic Technologist* for CPT codes 93X01, 93X02, and 93X04, and reduced times to 10, 5, and 18 minutes, respectively.

For CPT codes 33X01-33X11, the PE Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs. The number of office visits was adjusted formulaically for CPT codes 33X05, 33X07, 33X08, and 33X10 as determined by the RUC.

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
CPT codes 33X01-33X11 and 93X01-93X04 will be placed on the New Technology list to be reviewed by the RUC in three years.

<u>Diaphragm Repair (Tab 9)</u>
Vigneshwar Kasirajan, MD (STS), Daniel McCarthy, MD (STS), Matthew Reinersman, MD (STS), Jospeh Turek, MD (STS)

At the May 2025 CPT Editorial Panel meeting, one code was created to report thoracoscopic plication of the diaphragm for eventration or paralysis and CPT code 39545 was revised to specify plication of the diaphragm for eventration or paralysis, via thoracotomy. The transabdominal approach was deleted from CPT code 39545, and the transthoracic approach was clearly defined as via thoracotomy. These code changes more accurately capture the current procedures performed to treat symptomatic diaphragmatic eventration or paralysis.

Compelling Evidence
The specialty societies presented compelling evidence to support a change in physician work due to a change in patient population and a change in technique/technology. The prior code descriptor for 39545 describes both transabdominal and transthoracic approaches together. Transabdominal refers to an open laparotomy approach, and transthoracic refers to a thoracotomy approach. The transthoracic (ie, open thoracotomy) approach requires greater complexity with respect to anesthesia strategy, positioning, and incisional approach (thoracotomy) compared to a transabdominal approach (ie, open laparotomy). These distinct approaches represent differing surgical entrance points and operating within different body cavities, which do not represent similar physician work. Regarding a change in

patient population and technology, Video-Assisted Thoracic Surgery (VATS) (thoracoscopic) diaphragm plication has been reported in the literature for over 20 years and has become common practice in most institutions and training programs. As a result, the open approach described by code 39545 is now used primarily in a complex patient population that cannot be safely treated with VATS thoracoscopic techniques due to adhesions, anatomy, inability to tolerate one lung ventilation, or other comorbidities. Based on Medicare claims data over the last 10 years, the volume has been slowly decreasing. However, there is no equivalent evidence to suggest a decreasing prevalence of this disease; therefore, the decrease likely represents a shift from open to thoracoscopic operations, which are difficult to directly measure as they are currently reported with an unlisted diaphragm code. Thoracoscopic and laparoscopic approaches were not available when 39545 was last valued, and these new technologies have shifted the patient population to a more technically complex cohort, resulting in longer intra-service times. **The RUC accepted compelling evidence based on a change in patient population and a change in technique/technology.**

39545 ***Plication of diaphragm for eventration or paralysis, via thoracotomy***
The RUC reviewed the survey results from 58 surgeons and recommends a work RVU of 18.45 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 45 minutes of pre-service evaluation time, 15 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 1-99233, 1-99232, 1-99231, 1-99238, 2-99213, totaling 419 minutes. The hospital visits are necessary to manage systemic symptoms, side effects from surgery, and risk management of the patient's hemodynamics, chest tube, and postoperative pain. Further, respiratory support is needed, which typically includes monitoring for complications such as respiratory distress, esophageal and bowel dysfunction, infection, bleeding, and other postoperative risk factors related to the thoracotomy and diaphragmatic plication. Post-operative imaging, most commonly chest x-rays, is ordered to assess the surgical outcome of plication and rule out common complications. The post-operative office visits are necessary for the patient to be able to assess for changes from the plication and any adverse events such as pleural effusion.

For this procedure via the open thoracotomy approach, more time is spent opening and closing the much longer rib-cutting thoracotomy incision. Less time is spent plicating the diaphragm because of the bigger opening allowing for direct visualization and the ability to palpate the leaves of the diaphragm before each pass of the needle. Palpation of the diaphragm decreases the risk of injuring non-visualized intra-abdominal structures. This patient population is more complicated compared to the thoracoscopic approach, and it is specific to a population where the thoracoscopic approach cannot be performed.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference service code 32505 *Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial* (work RVU = 15.75, 90 minutes intra-service, and 427 minutes total time) and second top key reference service code 43334 *Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis* (work RVU = 22.12, 180 minutes intra-service, and 549 minutes total time). For the first key reference code 32505, survey respondents indicated that the surveyed code was identical or somewhat more intense/complex than the reference code. Additionally, the survey respondents indicated that the surveyed code was identical, somewhat more, and much more intense when compared to the second key reference code 43334. Therefore, the surveyed code work RVU is appropriately bracketed by the intra-service time with slightly lower total time and significantly more intensity/complexity compared to the reference codes supporting the recommended work RVU.

For additional support, the RUC referenced MPC codes 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.75, 103 minutes intra-service, and 337 minutes total time) and 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service, and 404 minutes total time). The surveyed code work RVU is appropriately bracketed by the MPC codes, given the similar intra-service times, although higher total time and slightly lower intensity and complexity of the surveyed code. The RUC also referenced CPT code 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* (work RVU = 18.63, 120 minutes intra-service, and 405 minutes total time). The reference code and surveyed code have identical intra-service time and similar total time, and therefore should be valued similarly. **The RUC recommends a work RVU of 18.45 for CPT code 39545.**

395X2 *Thoracoscopy, surgical, with plication of diaphragm for eventration or paralysis*
The RUC reviewed the survey results from 73 surgeons and recommends a work RVU of 20.00 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 42 minutes of pre-service evaluation time, 15 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 1-99233, 1-99232, 1-99238, 2-99213, totaling 396 minutes. The hospital visits are necessary to manage systemic symptoms, side effects from surgery, and risk management of the patient's hemodynamics, chest tube, and postoperative pain. Further, respiratory support is needed, which typically includes monitoring for complications such as respiratory distress, esophageal and bowel dysfunction, infection, bleeding, and other postoperative risk factors related to the thoracotomy and diaphragmatic plication. Post-operative imaging, most commonly chest x-rays, is ordered to assess the surgical outcome of plication and rule out common complications. This procedure requires one less hospital stay due to the incision size of the thoracoscopic approach compared to the larger incision for the thoracotomy approach. The post-operative office visits are necessary for the patient to be able to assess for changes from the plication and any adverse events, such as pleural effusion.

For this procedure performed via the thoracoscopic approach, less time is spent opening and closing the 3-5 significantly shorter thoracoscopic port sites. Specifically, more time is spent plicating the diaphragm because of a more challenging visualization field. This is due to a large, raised, billowing diaphragm, which continually needs repositioning and a decreased ability to palpate the leaves of the diaphragm increases worry of injuring the underlying abdominal contents. This procedure is more complex than family code 39545 due to the lack of tactile feedback and technical complexity of placing sutures in a minimally invasive manner.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference service codes 32673 *Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral* (work RVU = 21.13, 150 minutes intra-service, and 447 minutes total time) and 32672 *Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed* (work RVU = 27.00, 120 minutes intra-service, and 567 minutes total time). Survey respondents indicated that the surveyed code had either identical or more stress, physical effort, and skill when compared to key reference service code 32673. Specifically, the surgical visualization for the surveyed code is not as clear as the reference code 32673. This increases overall intensity and complexity as the surgeon is placing blind stitches for repositioning the elevated diaphragm. Further, for the second reference

code, 32672, which has a higher work RVU and total time than the surveyed code, the survey respondents indicated that the technical skill/physical effort was identical to, somewhat more, or more complex compared to the reference code. The technical skill and physical effort of the surveyed code are identical or more complex when compared to reference code 32673 because the end result of plication is a reduction in the size of the markedly redundant elevated diaphragm striving to get the correct tension, and the reference code is a resection of significantly over-inflated lung, but ultimately not resecting too much lung.

For additional support, the RUC referenced MPC codes 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* (work RVU = 17.75, 103 minutes intra-service, and 337 minutes total time) and 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU = 21.16, 120 minutes intra-service, and 404 minutes total time). The surveyed code work RVU is appropriately bracketed by the MPC codes, given the similar intra-service times and intensity/complexity, although lower total time of the surveyed code. The RUC also referenced CPT code 27280 *Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed* (work RVU = 20.00, 120 minutes intra-service, and 383 minutes total time). The reference code and surveyed code have identical intra-service time and similar total time and therefore should be valued similarly. **The RUC recommends a work RVU of 20.00 for CPT code 395X2.**

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 specialties clarified that SA054 *pack, post-op incision care (suture)* is typical for removal of the retained suture at the chest tube site. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT code 395X2 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.

Endoscopic Submucosal Dissection, Upper and Lower GI (Tab 10)
Robert Cameron, MD (ACG), Seth Gross, MD (ASGE), Srihari Mahadev, MD (ASGE), Ketan Sheth, MD (SAGES)

Endoscopic submucosal dissection (ESD) is a minimally invasive endoscopic surgical procedure for the curative resection of larger and more histologically advanced epithelia-based lesions, including early cancer and submucosal carcinomas of the upper and lower gastrointestinal (GI) tract. This technique achieves oncologic outcomes traditionally associated with open or laparoscopic surgery for lesions that are too advanced for standard endoscopic mucosal resection (EMR). Considering the complexity, anesthesia requirements, specialized electrosurgical equipment, hemostatic/closure devices, the need for immediate access to multi-disciplinary rescue resources, and post-procedure monitoring, this service must be performed in the hospital outpatient setting. At its May 2025 meeting, the CPT Editorial Panel approved the creation of this new code family, which consists of two new codes to describe ESD of both the upper and lower GI tract, including mucosal closure. This new family of codes was surveyed for the September 2025 RUC meeting.

Global Period
The specialties maintained a 000-day global period for ESD is appropriate, as there is no scheduled postoperative care with the performing physician beyond immediate recovery, and any subsequent encounters are unrelated to the procedure. This preserves a resource-accurate work and practice expense valuation. A question was raised concerning what would happen if there were an immediate complication. The specialties noted that surgical staff would respond, but that delayed complications are uncommon, and pain and/or post-op bleeding are not typical. Patients who receive ESD are typically referred to by another physician, such as a gastroenterologist. On the day of the procedure, these patients are managed by the performing physician for signs of complications immediately or within the next 23 hours. After that, the patient will return to follow up with the physician who made the referral for ESD.

4XX01 ***Endoscopic submucosal dissection (ESD) of upper gastrointestinal tract, including mucosal closure, when performed***
The RUC reviewed survey results from 66 gastroenterologists and recommends the survey 25th percentile work RVU of 15.00, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of scrub/dress/wait time, 150 minutes of intra-service time and 33 minutes of immediate post-service time, which equals 236 minutes of total time.

To support the recommended work RVU of 15.00, the RUC compared the surveyed code to the top key reference service 49596 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated* (work RVU = 18.67, 160 minutes intra-service time, 270 minutes total time) and second top key reference service 49615 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible* (work RVU = 11.46, 100 minutes intra-service time, 190 minutes total time). The RUC notes that together the two key reference services selected by survey respondents make for strong comparator codes, recognizing they bracket the survey 25th percentile work RVU of 15.00, as well as total time. The top key reference service requires 160 minutes of intra-service time, which is comparable to the 150 minutes of intra-service time required for the surveyed code; considering CPT code 49596 requires more total time overall and is more intense/complex to perform, this is an appropriate comparison. In terms of intensity/complexity, the RUC also acknowledges that the surveyed code is less intense/complex to perform than both key reference services, which is appropriate based on the overall differences in physician work and time between these procedures. Moreover, the RUC acknowledges the dearth of potential reference codes that are major surgical procedures with the 000-day global period that involve similar times, so the pool of potential reference codes was limited for this code family. Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform CPT code 4XX01 and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 15.00 for CPT code 4XX01.**

4XX02 ***Endoscopic submucosal dissection (ESD) of lower gastrointestinal tract, including mucosal closure, when performed***
The RUC reviewed survey results from 68 gastroenterologists and recommends the survey 25th percentile work RVU of 16.38, which appropriately accounts for the physician work typically required to perform this service. The RUC recommends 40 minutes pre-service evaluation time, 3

minutes pre-service positioning time, 10 minutes scrub/dress/wait time, 180 minutes intra-service time and 33 minutes immediate post-service time, which equals 266 minutes of total time.

In their presentation, the specialty societies explained that ESD of the lower GI tract typically requires more physician work than ESD of the upper GI tract. Lesions in the lower GI tract are typically larger and are located in the colon and rectum. There is typically a need for significant irrigation and aspiration, and the scope is often in retroflexion for long periods of time, making performance in this position technically challenging. The specialty societies clarified that ESD in the lower GI tract takes longer due to more advanced maneuvering, stability, and paradoxical intraoperative movement, to which the RUC agreed.

To support the recommended work RVU of 16.38, the RUC compared the surveyed code to the top key reference service 49596 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated* (work RVU = 18.67, 160 minutes intra-service time, 270 minutes total time) and second key reference service 49615 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible* (work RVU = 11.46, 100 minutes intra-service time, 190 minutes total time). The RUC notes that together the two key reference services selected by survey respondents make for strong comparator codes, recognizing that they bracket the survey 25th percentile work RVU of 16.38, as well as total time. The top key reference service requires slightly less intra-service time but requires nearly identical total time compared to the surveyed code. The RUC also acknowledges that while CPT code 4XX02 requires more intra-service time than either of the key reference services, the surveyed code is less intense/complex to perform, which is appropriate based on the overall differences in physician work and time between these procedures. Moreover, the RUC acknowledges the dearth of potential reference codes that are major surgical procedures with the 000-day global period that involve similar times, so the pool of potential reference codes was limited for this code family. Overall, the RUC recommendation of the survey 25th percentile work RVU appropriately reflects the physician work and time required to perform CPT code 4XX02 and maintains relativity within this code family and across comparable services. **The RUC recommends a work RVU of 16.38 for CPT code 4XX02.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee discussed the Extensive Use of Clinical Staff pre-service standard time package for the 000-day global period in the facility setting and agreed with the specialties that its use was warranted rather than the standard time package for endoscopy. ESD is endosurgery, not traditional diagnostic/therapeutic endoscopy, and is analogous to peroral endoscopic myotomy (POEM) and endoscopic sleeve gastroplasty (ESG). These 090-day global period services were included as PE reference codes to compare with the ESD procedures. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT codes 4XX01 and 4XX02 will be placed on the New Technology list to be reviewed by the RUC in three years. The specialty societies expect these to be low-volume services.

Congenital Duodenal Obstruction Repair (Tab 11)
Charles Mabry, MD (ACS), Don Selzer, MD (ACS), Richard Weiss, MD (ASPA)

At the May 2025 CPT Editorial Panel meeting, two new codes were created to report surgical treatment for congenital duodenal obstruction via an open or laparoscopic approach, that were previously reported using unlisted codes. These procedures are performed on infants and are not anticipated to be reported in the Medicare population.

44XX1 ***Duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction***
The RUC reviewed the survey results from 83 surgeons and recommends a work RVU of 50.00 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 60 minutes pre-service evaluation time, 12 minutes positioning time, 10 minutes scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 2-99291 critical care visits, 3-99233, 6-99232, 10-99231 subsequent hospital inpatient visits, 1-99238 discharge visit, 1-99214 and 1-99213 post-operative office visits, totaling 1,078 minutes.

For this procedure, substantial pre-service work is required to ensure optimal clinical outcomes in the premature neonate for whom duodenoduodenostomy or duodenojejunostomy is lifesaving. The preoperative phase involves review of extensive diagnostic evaluation, including laboratory testing and advanced imaging studies, to delineate the anatomy and characterize the degree of congenital duodenal obstruction. These assessments are critical for operative planning and perioperative risk stratification. Coordination with pediatric anesthesia and the neonatal intensive care unit (NICU) team is essential to establish a comprehensive perioperative management plan. In addition, detailed discussions are undertaken with the parents or legal guardians to review the procedure, potential complications, and the anticipated postoperative course. Preoperative preparation includes careful patient positioning to allow optimal exposure of the operative field while maintaining the safety and integrity of the premature neonate. Due to the fragility of the patient's skin and peripheral nerves, additional time is devoted to achieving a stable and protective position to minimize the risk of pressure-related injury and to facilitate the intricate dissection required during the operation. The intra-service surgical component is technically complex and requires advanced operative skill. Achieving exposure of the retroperitoneal space in a premature infant weighing approximately two kilograms demands precise and delicate dissection. Mobilization of the colon and splenic flexure is necessary to access the duodenum. This dissection must be performed with extreme care to avoid injury to the critical vascular and biliary structures of the porta hepatis, including the portal vein, hepatic artery, common bile duct, inferior vena cava, and pancreas. The subsequent repair of the duodenal atresia involves meticulous suture technique under magnification to maintain patency and prevent leakage. Given the markedly limited circulating blood volume in a neonate, even a minor vascular injury carries significant mortality risk, underscoring the technical demands of the procedure. In the postoperative phase, the neonate remains critically ill and is managed primarily in the NICU. Premature neonates often experience delayed extubation because they are slow to recover from general anesthesia. Nutritional advancement is gradual, as feeding tolerance can be limited following relief of an obstruction that existed throughout gestation. Additionally, many of these patients have significant comorbidities, such as congenital heart disease or other gastrointestinal atresias, which complicate recovery and necessitate prolonged, intensive postoperative management.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference service codes 44127 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering* (work RVU = 49.30, 150 minutes intra-service, and 1,357 minutes total time) and 44126 *Enterectomy, resection of small*

intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering (work RVU = 42.23, 120 minutes intra-service, and 1,125 minutes total time). Compared to the key reference services, the surveyed code is significantly more demanding and intense/complex. A duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction usually requires greater technical skill and is considered more intense and complex than a standard single resection and anastomosis of the proximal small intestine, mostly because of anatomical size/difficulty, risk of injury to critical structures, and the requirement for precise mobilization in a highly confined retroperitoneal space with vital nearby structures (pancreas, bile duct, ampulla of Vater). The duodenum's fixed retroperitoneal position complicates exposure and manipulation. The surveyed code is technically more challenging, especially in premature neonates, due to the size and thickness of duodenal tissue and proximity to major vessels and ducts and is often considered one of the more complex neonatal gastrointestinal procedures due to challenging anatomy and high risk for intraoperative complications.

For additional support, the RUC referenced MPC codes 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts* (work RVU = 39.88, 193 minutes intra-service, and 717 minutes total time) and 43117 *Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)* (work RVU = 57.50, 330 minutes intra-service, and 1,067 minutes total time). The surveyed code work RVU is appropriately bracketed by the MPC reference codes. While the intra-service time is lower than the reference codes, the intensity and complexity of the intra-service period is significant as previously described. Additionally, the total time of the surveyed code is higher than both MPC reference codes, which further supports the recommended work RVU. **The RUC recommends a work RVU of 50.00 for CPT code 44XX1.**

44XX2 ***Laparoscopy, surgical; duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction***

The RUC reviewed the survey results from 69 surgeons and recommends a work RVU of 52.60 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 60 minutes pre-service evaluation time, 15 minutes positioning time, 10 minutes scrub/dress/wait time, 180 minutes intra-service time, 30 minutes immediate post-service time, 2-99291 critical care visits, 2-99233, 4-99232, 9-99231 subsequent hospital inpatient visits, 1-99238 discharge visit, 1-99214 and 1-99213 post-operative office visits, totaling 986 minutes.

The surgical management of congenital duodenal obstruction in a premature neonate via laparoscopic duodenoduodenostomy or duodenojejunostomy requires extensive pre-, intra-, and postoperative work due to the complexity and fragility of the patient. This procedure represents one of the most technically demanding neonatal laparoscopic operations. The surgeon's cognitive load, constant vigilance, and fine motor precision are exceptionally high due to the confined operative field, fragility of tissues, and critical anatomy involved. The perioperative mortality risk remains significant, and intraoperative complications may be rapidly fatal without immediate recognition and response. The postoperative period also requires extensive continued surgical oversight given the high risk of complications and prolonged recovery in the NICU. Pre-service work requires additional time to review comprehensive diagnostic testing and advanced imaging to define the anatomical defect and guide operative planning. Given that the procedure is essential for survival, these evaluations are performed urgently and in close coordination with a multidisciplinary team. Detailed counseling is conducted with the parents or legal guardians to review the planned surgical intervention, discuss potential risks, and outline postoperative recovery expectations. Collaborative preoperative planning with pediatric anesthesia and the neonatal intensive care unit (NICU) team is critical to anticipate

perioperative challenges. Additional time is required for precise patient positioning to achieve optimal laparoscopic access to the operative field while minimizing the risk of peripheral nerve injury and preserving the delicate skin integrity of the premature neonate. Intra-service work is exceptionally demanding, both technically and physiologically, in a premature neonate. Laparoscopic entry and port placement are performed with extreme caution due to the small operating space and proximity of critical structures. The colon and splenic flexure must be mobilized to expose the duodenum, requiring careful retraction and dissection under magnification. During mobilization, vital structures within and adjacent to the porta hepatis—such as the portal vein, hepatic artery, common bile duct, inferior vena cava, and pancreas—must be meticulously preserved. The duodenal atresia is then repaired using precise laparoscopic suturing techniques, ensuring tension-free anastomosis and maintaining luminal patency. The limited circulating blood volume in a neonate means that even a minor vascular injury can precipitate rapid hemodynamic collapse, making surgical precision critical. Post-service work entails intensive NICU management, as the neonate remains critically ill following the procedure. Premature neonates frequently demonstrate delayed emergence from anesthesia, often necessitating continued mechanical ventilation upon NICU arrival. Initiation and progression of enteral feeds are typically slow, given that the obstruction has been present for the entirety of gestation and intestinal motility is markedly immature. Recovery is further complicated in many cases by significant comorbidities, including congenital heart defects or additional gastrointestinal atresias, necessitating ongoing multidisciplinary monitoring and intervention throughout the hospitalization.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference service codes 44127 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering* (work RVU = 49.30, 150 minutes intra-service, and 1,357 minutes total time) and 44126 *Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering* (work RVU = 42.23, 120 minutes intra-service, and 1,125 minutes total time). Compared to the key reference services, the surveyed code is significantly more demanding and intense/complex. A duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction usually requires greater technical skill and is considered more intense and complex than a standard single resection and anastomosis of the proximal small intestine, mostly because of anatomical difficulty, risk of injury to critical structures, and the requirement for precise mobilization in a highly confined retroperitoneal space with vital nearby structures (pancreas, bile duct, ampulla of Vater). The duodenum's fixed retroperitoneal position complicates exposure and manipulation. The surveyed code is technically more challenging, especially in very small neonates, due to the size and thickness of duodenal tissue and proximity to major vessels and ducts and is often considered one of the more complex neonatal gastrointestinal procedures due to challenging anatomy and high risk for intraoperative complications. The laparoscopic approach further increases technical intensity as it involves operating within a very limited space and requires advanced skills. Challenges include limited visualization and the need for precise suturing and tissue manipulation with long, slender instruments. Errors in precision are not forgiving and may result in conversion to an open procedure.

For additional support, the RUC referenced codes 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts* (work RVU = 39.88, 193 minutes intra-service, and 717 minutes total time) and 43117 *Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)* (work RVU = 57.50, 330 minutes intra-service, and 1,067 minutes total time). They surveyed code work RVU is appropriately bracketed by the MPC reference codes. While the intra-service time is lower than the reference codes, the intensity and complexity of

the intra-service period is significant as previously described, which supports the recommended work RVU. **The RUC recommends a work RVU of 52.60 for CPT code 44XX2.**

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.**

Irreversible Electroporation of Tumor – Pancreas (Tab 12)
Charles Mabry, MD (ACS), Don Selzer, MD (ACS)

In May 2025, the CPT Editorial Panel approved the addition of a code to report open irreversible electroporation (IRE) ablation of tumors of the pancreas and revision of a Category III code to exclude open ablation via IRE of tumors of the pancreas.

48XXX ***Ablation, irreversible electroporation of tumor(s) of the pancreas, open, including imaging guidance***
The RUC reviewed the survey results from 32 general surgeons, surgical oncologists and hepatopancreatobiliary surgeons and determined that the survey 25th percentile work RVU of 25.19 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 50 minutes pre-service evaluation time, 10 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 30 minutes immediate post-service time, 1-99233, 2-99232, 3-99231 subsequent hospital inpatient or observation care visits, 1-99238 discharge visit, and 1-99214 and 2-99213 office visits for 544 minutes total time as supported by the survey.

Pre-time package 4 *Difficult patient/Difficult procedure* for the facility setting was selected with adjustments to the evaluation and positioning times. An additional 10 minutes of physician evaluation time is necessary for extensive preoperative review of angiographic studies, magnetic resonance imaging (MRI), computed tomography (CT) scans, and associated radiology reports to guide surgical planning. These imaging reviews are essential for determining vascular involvement, tumor margins, and the feasibility of resection versus ablation. In addition, additional positioning time is necessary due to the complexity of aligning the patient, anesthesia lines, intraoperative imaging guidance equipment, and IRE probe systems with associated monitoring and energy delivery devices. This positioning must allow unobstructed operative access to the pancreas while maintaining the accuracy and safety of probe placement during the procedure.

The specialty noted that the surgeon approaches the case with the primary intent of resecting the pancreatic tumor if technically feasible. However, the IRE system is prepared and available intraoperatively should the tumor be deemed unresectable upon direct visualization and assessment. In such cases, IRE serves as a critical alternative therapy for local control of the tumor. Most patients undergoing this procedure have locally advanced pancreatic cancer and have previously completed chemotherapy, resulting in tissue changes, adhesions, and increased complexity in surgical management. Postoperatively, these patients require close monitoring for postoperative complications related to both open pancreatic surgery and IRE technology, including risk of pancreatitis, vascular injury, and arrhythmias from energy delivery. Standard postoperative management includes a lengthy inpatient hospitalization to allow for vigilant observation, pain control, nutritional support, and multidisciplinary care coordination. The RUC concurred with the inpatient length of stay

recommendation and with the survey median response of two 99213 and one 99214 post-operative office visits.

To justify a work RVU of 25.19, the RUC compared CPT code 48XXX to the top key reference service code 47380 *Ablation, open, of 1 or more liver tumor(s); radiofrequency* (work RVU = 24.56, 200 minutes intra-service time and 550 minutes total time) and noted that the intra-service time is less for the surveyed code yet intensity is greater, justifying the higher work value. The RUC also compared the surveyed code to the second key reference service code 49189 *Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm* (work RVU = 40.00, 310 minutes intra-service time and 814 minutes total time) and noted that the reference service has much more intra-service and total time than the surveyed code denoting more physician work, and is therefore appropriately valued higher.

It was further noted that survey respondents who selected the top two key reference codes rated the intensity and complexity measures for the surveyed code as being significantly greater. The portal vein, superior mesenteric vein (SMV), superior mesenteric artery (SMA), celiac artery, and all its branches are within millimeters of where these probes are placed, and the anatomy is markedly distorted from the locally advanced tumor, prior chemotherapy, and often radiation treatment these patients have already received. Exposing and operating on the pancreas next to the SMA/SMV/celiac artery is far more intense in this domain than a liver ablation or excision/destruction of a large peritoneal tumor.

The RUC also agreed that the surveyed code is appropriately bracketed by the MPC codes 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* (work RVU = 23.53 and 150 minutes intra-service time and 502 minutes total time) and 34705 *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58 and 150 minutes intra-service time and 512 minutes total time). The RUC concluded that CPT code 48XXX should be valued at the 25th percentile work RVU, as supported by the survey. **The RUC recommends a work RVU of 25.19 for CPT code 48XXX.**

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
CPT code 48XXX will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Percutaneous Lumbar Decompression (Tab 13)
Antigone Argyriou, MD (AAPM&R), Minhajuddin Khaja, MD (SIR), Carlo Milani, MD (AAPM&R), Richard Rosenquist, MD (ASA), Clemens Schirmer, MD (CNS)

At the January 2025 RUC meeting, the surveying societies requested deletion of CPT code 62287 due to declining Medicare utilization. At the May 2025 CPT Editorial Panel meeting, additional utilization estimates were reviewed, and requests from neurosurgery and radiology were received to retain the code. It was determined that the code should be maintained within the CPT code set to report this service. Since the code was not surveyed with family codes 62330 and 62331 in January 2025, it was placed back on the LOI for survey at the September 2025 RUC meeting.

62287 ***Decompression percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar***
The RUC reviewed the survey results from 38 surgeons and recommends a work RVU of 7.06 based on the survey 25th percentile, which maintains relativity within the family for this code. The RUC recommends 38 minutes pre-service evaluation time, 10 minutes positioning time, 10 minutes scrub/dress/wait time, 37 minutes intra-service time, 20 minutes immediate post-service time, 0.5-99238 discharge visit, and 2-99213 post-operative office visits, totaling 180 minutes. The RUC agreed with the specialty recommendation that a half-day discharge visit and 2-99213 office visits are typical. The post-operative office visits are necessary for the patient to confirm a successful outcome of the procedure at 7-10 days post-surgery and 6 weeks post-surgery.

For this procedure, the skin is anesthetized at the entry site, and an introducer needle is carefully advanced along a posterior lateral trajectory into the nucleus pulposus of the disc using regular fluoroscopic guidance. Meticulous care is taken to avoid structures like the exiting nerve root medially, and vascular structures, or the viscera laterally. A guide wire is then placed, the tract is dilated, and a working cannula is then placed and advanced into the disc. A discogram is then performed with contrast to confirm placement and to evaluate the structural integrity of the annulus. Through that cannula, instruments are inserted and used to remove small portions of the nucleus pulposus from the posterior third of the disc. Each pass requires regular fluoroscopic confirmation and tactile judgment to ensure that you are in the nucleus and to preserve the annular integrity. Once adequate decompression is achieved, the area is flushed, and homeostasis is confirmed, closure occurs. The goal of this procedure is to reduce intradiscal pressure and decompress the nerve root to reduce nerve irritation and related pain.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference service codes 22869 *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level* (work RVU = 7.03, 45 minutes intra-service, 175 minutes total time) and 63662 *Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed* (work RVU = 11.00, 60 minutes intra-service, 243 minutes total time). A majority of the survey respondents that selected one of the two top key reference codes indicated that the surveyed code is identical or somewhat more intense/complex than the key reference codes. The intra-service time is lower than the key reference services, but the post-operative work is similar, as supported by the total time. Therefore, the recommended work RVU of 7.06 is appropriately bracketed by the reference codes. The top key reference code 22869 provides a strong relative

comparison when compared to intra-service time, total time, and post-operative work. Therefore, the codes should be valued similarly.

For additional support, the RUC referenced MPC codes 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, 45 minutes intra-service, 161 minutes total time) and 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, 60 minutes intra-service, 183 minutes total time). The recommended work RVU is appropriately bracketed by the MPC reference codes. The intra-service time of the surveyed code is lower than both codes; however, the total time is very close to MPC code 14060. Thus, the surveyed code recommended work RVU is appropriately supported relative to the reference MPC codes.

Further, CPT code 29881 *Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU = 7.03, 40 minutes intra-service, 194 minutes total time) has similar intra-service time and total time. Therefore, the surveyed code should be valued similarly to the reference code. **The RUC recommends a work RVU of 7.06 for CPT code 62287.**

62330 ***Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one interspace, lumbar***
62331 ***Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)***
CPT codes 62330 and 62331 were surveyed for the January 2025 RUC meeting. In the CY 2026 MFS Proposed Rule, the RUC recommended work values of 8.00 for CPT code 62330 and 4.25 for CPT code 62331 were accepted. **The RUC agreed with the specialty societies and recommends affirmation of the current work RVU of 8.00 for CPT code 62330 and 4.25 for CPT code 62331.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made no modifications to the standard 090-day global inputs for CPT code 62287. The PE Subcommittee agreed to affirm the January 2025 PE recommendations for CPT codes 62330 and 62331. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

<u>Rotational Vestibular Assessment (Tab 14)</u>
Deborah Carlson, PhD (ASHA), Terry Fife, MD (AAN), Patricia Gaffney, AuD (AAA), Erin L. Miller, AuD (AAA), Paul Pessis, AuD (AAA), Marianna Spanaki, MD (AAN)

In April 2024, the Relativity Assessment Workgroup (RAW) identified code 92546 as reported with 92540 by the same physician or qualified health care professional on the same date of service 84% of the time based on 2022 Medicare Utilization data. However, code 92540 is reported with 92546 less than 50% of the time. In September 2024, the RAW reviewed the action plan and recommended referral to the CPT Editorial Panel to revise the descriptor for code 92546 to clarify the service so that it is no longer typically reported with code 92540 more than 75% of the time. Specifically, CPT code 92546 is a separate and distinct service from CPT code 92540, in that 92546 utilizes the use of a calibrated, computer controlled rotary chair and requires different work and equipment than CPT code 92540. The specialties noted that the codes can still be reported together, although it is strongly

anticipated that it will be far less frequent (<50%). At the September 2025 CPT Editorial Panel Meeting, CPT code 92546 was deleted, and two new codes were added to report rotational vestibular assessment. The two new codes were surveyed for the September 2025 RUC meeting.

Compelling Evidence
The specialty societies presented compelling evidence to support a change in physician work due to a change in specialty. According to Medicare utilization data, the plurality of the billing is from audiology (31%), followed by neurology (29.8%), and otolaryngology (12.8%). Further, Audiology time is currently captured as clinical labor in practice expense. However, since 2009, audiologists may bill Medicare independently. As such, audiologists' time should not be captured under practice expense. Rather, audiology time should be accounted for in professional work. **The RUC accepted compelling evidence based on a change in specialty.**

92XX5 ***Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report;***
The RUC reviewed the survey results from 92 audiologists and neurologists and recommends a work RVU of 0.92 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 10 minutes of pre-service evaluation time, 25 minutes intra-service time, 10 minutes immediate post-service time, totaling 45 minutes.

For this procedure, the patient is strapped into the chair, goggles are placed, and their visual awareness is compromised. The chair is being moved in different directions, with varying intensities of movement. It is important to remember that these patients are also undergoing this service because they have had a long-standing vestibular history and are often frightened and anxious about the procedure. The service requires the skill of the physician/qualified healthcare professional (QHP) to make clinical decisions and interpret the results continuously throughout the entirety of the test. Further, monitoring the patient for symptom provocation so that real-time decision-making can be made is essential to the procedure.

To support the recommended work RVU, compared the surveyed code to the top key reference service codes 92519 *Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)* (work RVU = 1.20, 35 minutes intra-service, 50 minutes total time) and 92537 *Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)* (work RVU = 0.60, 30 minutes intra-service, 40 minutes total time). A majority of the survey respondents that selected the top key reference codes indicated that the surveyed code is more intense/complex. A majority of the survey respondents that selected the second key reference code indicated that the surveyed code and reference code have identical intensity. The surveyed code intra-service time is lower when compared to the key reference services; however, the total time and related intensity and complexity of the surveyed code are relative to the reference services. Therefore, the recommended work RVU is appropriately bracketed by the key reference services.

For additional support, the RUC referenced MPC codes 92517 *Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)* (work RVU = 0.80, 20 minutes intra-service, 32 minutes total time) and 92653 *Auditory evoked potentials; neurodiagnostic, with interpretation and report* (work RVU = 1.05, 30 minutes intra-service, 50 minutes total time). The MPC reference codes appropriately bracket the survey code work RVU, intra-service time, and total time, supporting the recommended work RVU and relativity within the MFS. **The RUC recommends a work RVU of 0.92 for CPT code 92XX5.**

92XX6 ***Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; with velocity step testing (VST) (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 80 audiologists and neurologists and recommends a work RVU of 0.48 based on the survey median, which maintains relativity within the family for this code. The RUC recommends 12 minutes intra-service and total time.

For this add-on procedure, vestibular step testing (VST) provides additional diagnostic information about central vestibular function and helps to distinguish lateralization of peripheral vestibular dysfunction. The equipment used is the same as it is for the base code 92XX5. The additional test allows for rotation of the chair at lower and higher velocities than the sinusoidal harmonic acceleration **(**SHA) testing in the base code and requires additional time for the testing. Specifically, the computer-controlled chair is abruptly accelerated in a clockwise direction to a designated velocity for 60 seconds before a rapid deceleration is immediately applied back to baseline velocity for an additional 60 seconds. The process is then repeated in a counterclockwise direction. The assessment consists of four low-velocity and four high-velocity targets, each involving 60 seconds of rotational movement. For maximizing the test findings, the physician/qualified health care professional (QHP) must be engaged with the patient throughout the test to secure valid results and will make real-time decisions to adjust the protocol.

To support the recommended work RVU, the RUC compared the surveyed code to the top key reference service codes 92621 *Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.35, 15 minutes intra-service and total time) and 92627 *Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.33, 15 minutes intra-service and total time). A majority of the survey respondents that selected the key reference codes indicated that the surveyed code is identical or more intense/complex. Although the intra-service and total time are slightly lower than the key reference service, the surveyed code is overall more intense and complex to perform and should be valued slightly higher.

For additional support, the RUC referenced MPC codes 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* (work RVU = 0.38, 15 minutes intra-service, 17 minutes total time) and 96168 *Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.60, 15 minutes intra-service and total time). The surveyed code intra-service time is lower when compared to the MPC codes; however, the surveyed code is more intense and complex to perform when compared to code 77001 and is identical to the intensity and complexity to perform MPC code 96168. Therefore, the recommended work RVU is appropriately supported by the MPC codes. **The RUC recommends a work RVU of 0.48 for CPT code 92XX6.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs and made minor modifications. The PE Subcommittee removed the supply input SJ010 *Basin, emesis* which was deemed to be not typically used for every patient. Further, equipment item ED021 *Computer, desktop, w-monitor* was removed as this input is considered an indirect expense in accord with CMS policy. The PE Subcommittee agreed with the specialty societies and is recommending a new equipment item for the *VNG Open Chair System*. This new system includes goggles. The "Other" equipment formula is used because the physician/audiologist time required to perform the rotational chair testing is accounted for in the work component rather than in the PE. The specialties clarified that the equipment is a fixed installation, bolted to the floor in a specialized room for this test, and cannot be moved. Further, the procedure is not typically performed with another procedure on the same day. The patient is sent specifically for the rotational vestibular assessment with the chair. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

New Technology
CPT code 92XX5 and 92XX6 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.

Intracoronary Drug Delivery Balloon Services (Tab 15)
Ed Tuohy, MD (ACC), Richard Wright, MD (ACC)

In May 2025, the CPT Editorial Panel created two new Category I CPT codes to describe percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloons (CPT codes 9XX04 and 9XX07). These two new codes join the percutaneous coronary intervention (PCI) code family, which was last reviewed by the RUC in April 2024. For the September 2025 RUC meeting, it was noted that in the CY2026 Medicare Physician Payment Schedule Proposed Rule, CMS proposed to accept the RUC recommended work RVU for all twelve codes in the family previously reviewed at the April 2024 RUC meeting.

9XX04 ***Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, single major coronary artery and/or its branch(es)***
The RUC reviewed the survey results from 99 interventional cardiologists and determined that the survey median work RVU of 10.00 appropriately accounts for the physician work required to perform this service. The RUC recommends 35 minutes pre-service evaluation time, 3 minutes pre-service positioning time, 10 minutes pre-service scrub/dress/wait time, 60 minutes intra-service time, and 21 minutes immediate post-service time.

The RUC agreed to align the pre-service times to be consistent for 9XX04 with the pre-service time for the other 000-day global codes included in the percutaneous coronary intervention code family to reflect the time typically required to perform the pre-service evaluation and other work to prepare for the procedure. The additional time is necessary to evaluate and prepare the access site(s) (one or both radial arteries and/or one or both femoral arteries). The myriad of techniques that are now available for percutaneous coronary intervention has expanded, and that requires a full discussion with the patient because each one carries separate risks. Left and right radial pulses are also evaluated using an Allen test to determine which are available for access and which of the two offers preferable access. It is typical for the physician to prepare at least two access sites. Many operators routinely provide an anti-vasospastic cocktail, which also takes additional time to prepare. As part of the evaluation, the operator discusses the results of Heart Team consultations (if performed) and describes various PCI

techniques, and the possibility of conversion to emergency surgery, among other typical scenarios. The Heart Team for coronary revascularizations is a multidisciplinary team convened to evaluate complex patients and help allow patient-centered, evidence-based clinical decisions for patients who are considered for coronary revascularization.

The specialty societies noted that CPT code 9XX04 is inclusive of all of the work included in CPT code 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery and/or its branch(es)* (CY2026 NRPM work RVU= 8.35, CY2026 NPRM intra-service time of 48 minutes, CY2026 NPRM total time of 123 minutes) and also the additional work to provide percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon. Therefore, the specialty societies noted, and the RUC concurred that a proposed value of 10.00 maintains the appropriate rank order with CPT code 92920.

The specialty society noted that the typical patient has in-stent restenosis, where a blockage or narrowing reoccurs in the portion of the coronary artery and/or its branches previously treated with a stent. When the surgeon encounters in-stent restenosis, they must perform extensive analysis to figure out the mode of failure of the stent and then address that mode of failure. Often, that mode of failure is calcium restriction of expansion of the stent, which requires multiple steps to further dilate the vessel and further reanalyze, iteratively. The vessel needs to be completely optimized for the effective drug-coated balloon delivery to ensure a durable result; this takes a significant amount of extra work beyond what would be involved in a regular balloon angioplasty. The specialty also noted that this service is not typically performed with intravascular ultrasound or any other imaging modality.

To support the recommended work RVU of 10.00, the RUC compared the surveyed code to CPT code 33991 *Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture* (work RVU=8.84, intra-service time of 60 minutes, total time of 113 minutes) and noted that both services involve the same amount of intra-service time though the surveyed code typically involves 16 more minutes of total time. The specialty noted and the RUC concurred that the reference code is less intense than the surveyed code, as it is transvenous, as opposed to being an arterial entry for engagement of the coronary artery. For additional support, the RUC compared the surveyed code to CPT code 33530 *Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)* (work RVU= 10.13, 70 minutes intra-service time and 112 minutes total time) and noted that although the surveyed code involves less intra-service time, it involves more total time. Both procedures typically involve a similar amount of physician work. **The RUC recommends a work RVU of 10.00 for CPT code 9XX04.**

9XX07 ***Percutaneous transcatheter therapeutic drug-delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), single major artery and/or its branches (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 95 interventional cardiologists and determined that the survey 25th percentile work RVU of 4.38 appropriately accounts for the physician work required to perform this service. The RUC recommends 48 minutes intra-service and total time for this add-on procedure.

The specialty society noted that this add-on service is to be used when a drug-coated balloon is used in addition to another intervention in the same coronary artery. The specialty society indicated that

the typical patient would undergo atherectomy (separately reported), and if the vessel is felt to be too small caliber for stenting. Therefore, the atherectomy is followed by drug-coated balloon treatment.

In general, the specialty society noted that this add-on service would be performed when the artery is either too small or too diffusely diseased for a stent to be an option. There is a high degree of restenosis with the standard non-drug balloon angioplasty, therefore a drug-coated balloon is used instead. The specialty societies also estimated that this service will likely be very infrequently performed, as the surgeon would always opt to use a stent if that were a viable option.

The RUC compared the surveyed code to second key reference code 37186 *Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)* (work RVU= 4.92, intra-service and total time of 60 minutes) and noted that the key reference code typically involves 12 more minutes of time and more physician work. The RUC concluded that these two services maintain appropriate relativity. For additional support, the RUC compared the surveyed code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 4.13, intra-service and total time of 40 minutes) and noted that the surveyed code involves more intra-service and total time; both services would have appropriate relativity to each other. **The RUC recommends a work RVU of 4.38 for CPT code 9XX07.**

Affirm RUC Recommendations
The RUC affirms its April 2024 work RVU recommendations of 8.35 for CPT code 92920, a work RVU of 10.13 for CPT code 92924, a work RVU of 10.00 for CPT code 92928, a work RVU of 11.94 for CPT code 92933, a work RVU of 11.30 for CPT code 92937, a work RVU of 12.72 for CPT code 92941, a work RVU of 13.69 for CPT code 92943, a work RVU of 2.97 for 92972, a work RVU of 1.75 for CPT code 92973, a work RVU of 12.00 for CPT code 92930, a work RVU of 15.00 for CPT code 92945, a work RVU of 1.80 for CPT code 93571, and a work RVU of 1.44 for CPT code 93572. CMS proposed to accept these RUC recommendations in the CY2026 Medicare Physician Fee Schedule Proposed Rule.

Practice Expense
The RUC recommends no direct practice expense inputs for CPT codes 9XX04 and 9XX07 as they are facility-only services.

New Technology/New Services List
CPT codes 9XX04 and 9XX07 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.

<u>Laser Treatment for Inflammatory Skin Diseases (Tab 16)</u>
Ryan Hick, MD (AADA), Mark Kaufmann, MD (AADA)

The laser therapy for inflammatory skin conditions codes 96920, 96921 and 96922 were originally identified as potentially misvalued in 2008 via the CMS high volume growth screen. In October 2015, the RUC identified these codes via the high-volume growth screen with Medicare utilization of 10,000 or more that increased by at least 100% from 2008 through 2013. More recently, the code

family was surveyed for the April 2023 RUC meeting, after being flagged again for increasing utilization in January 2022. The code set subsequently underwent several CPT revisions.

Upon consideration at the April 2025 RUC meeting, the RUC concurred that the code descriptor changes since the laser codes were last reviewed in 2023 were editorial in nature (remove the word 'excimer'). However, the new code change application with expanded indications would require a RUC survey. The RUC agreed with the specialty society's request to affirm the current CMS values for CPT codes 96920, 96921 and 96922. In May 2025, the CPT Editorial Panel revised the three codes to reflect the intended use for inflammatory or auto-immune skin diseases (eg, psoriasis). Accordingly, the specialty society surveyed the code family for the September 2025 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 96920, 96921 and 96922 based on flaws in the prior valuation process and change in patient population.

Flawed Methodology
The specialty society believes, and the RUC agrees, that the methodology used by CMS in the CY2025 Medicare Physician Fee Schedule was flawed and led to incorrect assumptions and inaccurate valuation of laser codes CPT 96920, 96921 and 96922. For CY2025, CMS accepted the RUC recommended times but did not accept the RUC recommended values, resulting in anomalies. Instead, the Agency finalized lower work RVUs: 0.83 for 96920, 0.90 for 96921, and 1.15 for 96922.

Specifically, CMS finalized work RVUs based on crosswalks to CPT codes 11104 *Punch biopsy of skin (including simple closure, when performed); single lesion* and 11301 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm* for 96920 and 96921, respectively. For 96922, CMS used a purely formulaic approach, applying building block methodology and citing the RUC-recommended incremental difference of 0.25 work RVUs above 96921 to arrive at a final value of 1.15. CMS also calculated intra-service time ratios between the 2002 intra-service times, and the RUC recommended intra-service times for each code, multiplying that ratio by the 2002 work RVU.

In its rationale, CMS indicated that the physician times associated with these codes have fluctuated over time, while the work RVUs have remained largely unchanged. CMS expressed concern that the 2012 recommendations did not address this inconsistency and emphasized that significant decreases in time should correspond with decreases in work RVUs unless a clear rationale is provided for increased intensity. The specialty society believes CMS's methodology is flawed due to the use of time ratios across different time periods to justify reductions in work RVUs, particularly when the original 2002 values were not based on survey data but were established through crosswalks. Applying time-based calculations across periods where code descriptors have since been revised is not appropriate for valuing physician work. Calculating an intra-service time ratio based on the 2002 values is not representative of the actual time, intensity, and physician work involved in performing these services today. Further, CMS did not provide a clinical rationale to support the selected crosswalks to 11104 and 11301, which do not reflect the current clinical use, service characteristics, or intensity of laser treatment for inflammatory skin disease.

Change in patient population
The second argument in support of compelling evidence relates to a change in the patient population. Laser treatment for inflammatory and autoimmune skin diseases is now typically performed only in

those patients with contraindications for systemic agents, such as those with paradoxical biologic response, lack of response to systemic agents, preexisting immunosuppression or latent infections, or those patients with particularly recalcitrant disease. The code indications, previously limited to psoriasis, now encompass applicable inflammatory and autoimmune skin diseases, such as atopic dermatitis, vitiligo, and alopecia areata. Although psoriasis is anticipated to remain the typical condition treated by this modality, the patient population treated with ultraviolet laser has shifted as highly effective systemic biologics have replaced localized therapy. With biologics, the excimer laser device is used to treat patients who have not responded well to biologics or need extra treatment in hard-to-treat areas that are thick and recalcitrant to biologics. Therefore, the patient population has significantly changed since the last time the RUC recommendation was implemented by CMS.

The RUC concurred that there is compelling evidence that the physician work for these services has changed based on flawed methodology and change in patient population. The RUC agrees to consider increased times and work RVUs for CPT codes 96920, 96921 and 96922 based on the current survey data.

96920 ***Laser treatment, 308-312 nanometer wavelengths, for inflammatory or auto-immune skin diseases (eg, psoriasis); total area less than 250 sq cm***
The RUC reviewed the survey results from 37 dermatologists and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the physician work involved in this service. The RUC recommends 7 minutes pre-service evaluation time, 2 minutes pre-service positioning time, 1-minute pre-service scrub/dress/wait time, 12 minutes intra-service time, and 5 minutes post-service time for 27 minutes total time as supported by the survey.

Pre-service time package 5 *NF Proc w minimal anes care (if no deduct 1 min)* for the non-facility setting is supported. In addition, maintaining the current 2 minutes of pre-service positioning time to account for the necessary maneuvering and manipulation of the patient to allow access to sensitive treatment areas for the application of local anesthetic (eutectic mixture of local anesthetics (EMLA) cream), as needed; draping and positioning the patient for optimal access to each treatment site.

To justify a work RVU of 1.00, the RUC compared the surveyed code to the top key reference service code 11307 *Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm* (work RVU = 1.20, 21 minutes intra-service time and 32 minutes total time) and noted that the reference service has more intra-service time and total time than the surveyed code and is therefore appropriately valued higher. The RUC also compared the surveyed code to the second key reference service code 96574 *Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day* (work RVU = 1.01, 16 minutes intra-service time and 36 minutes total time) and noted that the reference service has a similar amount of physician work yet the surveyed code has less intra-service time and is more intense.

The RUC also compared the surveyed code to CPT code 20606 *Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.00, 10 minutes intra-service time and 27 minutes total time) and noted that the comparator code has similar intra-service time, identical total time and involves the same amount of physician

work. The difference in intra-service time is offset by the slightly higher intensity of CPT code 20606.

The RUC also offers strong comparisons between the surveyed code and MPC codes 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07, 12 minutes intra-service time and 24 minutes total time) and 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* (work RVU = 1.10, 12 minutes intra-service time and 27 minutes total time) noting the identical intra-service times, yet the comparator codes involve slightly more physician work and intensity and are therefore both appropriately valued higher than the surveyed code.

For additional support, the RUC compared the surveyed code to MPC codes 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) and 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14, 15 minutes intra-service time and 27 minutes total time) and noted that the comparison codes appropriately bracket the recommended work RVU. The RUC concluded that CPT code 96920 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.00 for CPT code 96920.**

96921 ***Laser treatment, 308-312 nanometer wavelengths, for inflammatory or auto-immune skin diseases (eg, psoriasis); 250 sq cm to 500 sq cm*** The RUC reviewed the survey results from 37 dermatologists and determined that the survey 25th percentile work RVU of 1.24 appropriately accounts for the physician work involved in this service. The recommendation also provides for a stepwise progression of the procedure based on the size of the wound or lesion. The RUC recommends 7 minutes pre-service evaluation time, 2 minutes pre-service positioning time, 1 minute of pre-service scrub/dress/wait time, 17 minutes intra-service time, and 5 minutes post-service time for 32 minutes total time as supported by the survey. The RUC acknowledged that the increase in intra-service time is attributed to the more difficult typical patient and increased complexity of the cases. The specialty society believes, and the RUC agrees, that the median intra-service times from the current survey more accurately reflect the physician time and intensity associated with these services than the current values.

Pre-service time package 5 *NF Proc w minimal anes care (if no deduct 1 min)* for the non-facility setting is supported. In addition, maintaining the current 2 minutes of pre-service positioning time to account for the necessary maneuvering and manipulation of the patient to allow access to sensitive treatment areas for the application of local anesthetic (EMLA cream), as needed; draping and positioning the patient for optimal access to each treatment site.

To justify a work RVU of 1.24, the RUC compared the surveyed code to the top key reference service code 12014 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm* (work RVU = 1.57, 20 minutes intra-service time and 32 minutes total time) and noted that the reference service has the same total time yet more intra-service time and is more intense, justifying a higher value than the surveyed code. The RUC also compared the surveyed code to the second key reference service code 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU = 2.39, 30 minutes intra-service time and 47 minutes total time) and noted that the

reference service has much more intra-service and total time than the surveyed code and is therefore appropriately valued higher.

For additional support, the RUC noted that the surveyed code is closely bracketed by MPC codes 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14, 15 minutes intra-service time and 27 minutes total time) and 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44, 17 minutes intra-service time and 29 minutes total time). Of note, MPC code 12004 has identical intra-service time, yet the comparator code involves more physician work and intensity and is therefore appropriately valued higher than the surveyed code. The RUC concluded that CPT code 96921 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.24 for CPT code 96921.**

96922 ***Laser treatment, 308-312 nanometer wavelengths, for inflammatory or auto-immune skin diseases (eg, psoriasis); over 500 sq cm***
The RUC reviewed the survey results from 37 dermatologists and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the physician work involved in this service. The RUC recommends 7 minutes pre-service evaluation time, 2 minutes pre-service positioning time, 1-minute pre-service scrub/dress/wait time, 24 minutes intra-service time, and 5 minutes post-service time for 39 minutes total time as supported by the survey. The specialty society believes, and the RUC agrees, that the median intra-service times from the current survey more accurately reflect the physician time and intensity associated with these services than the current values. This service covers the largest area, and the physician must perform treatment sequentially to all lesions, taking care to avoid overlapping and modifying fluences as needed.

Pre-service time package 5 *NF Proc w minimal anes care (if no deduct 1 min)* for the non-facility setting is supported. In addition, maintaining the current 2 minutes of pre-service positioning time to account for the necessary maneuvering and manipulation of the patient to allow access to sensitive treatment areas for the application of local anesthetic (EMLA cream), as needed; draping and positioning the patient for optimal access to each treatment site.

To justify a work RVU of 1.50, the RUC compared CPT code 96922 to the to the top key reference service code 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU = 2.39, 30 minutes intra-service time and 47 minutes total time) and to the second key reference service code 12018 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm* (work RVU = 3.61, 45 minutes intra-service time and 64 minutes total time) noting that the reference services require more intra-service and total time than the surveyed code and are appropriately valued higher.

The RUC emphasized the appropriate comparison of CPT code 96922 to MPC code 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44, 17 minutes intra-service time and 29 minutes total time) noting that both involve treatment over a larger body surface area. The surveyed code requires more intra-service and total time and is therefore valued higher than the comparator code. The RUC also compared the surveyed code to MPC code 64644 *Chemodenervation of one extremity; 5 or more muscles* (work RVU = 1.82, 25 minutes intra-service time and 45 minutes

total time) and noted that the survey 25th percentile value is appropriately bracketed by these comparator codes.

The RUC concluded that CPT code 96922 should be valued at the 25th percentile work RVU as supported by the survey. This recommendation provides a stepwise progression of the procedure based on the size of the wound or lesion and preserves rank order within the family. **The RUC recommends a work RVU of 1.50 for CPT code 96922.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for CPT codes 96920, 96921, and 96922 and made no modifications. The specialty presented the current direct inputs with an increase in clinical staff time for the code family related to CA018 *Assist physician or other qualified healthcare professional---directly related to physician work time (100%)*. The increased time for CA018 is entirely accounted for due to an increase in physician intra-service time.

The specialty society confirmed that the excimer laser remains the typical equipment used for this code set. The RUC acknowledged that CMS did not accept the May 2023 RUC recommendation to change the business model for excimer lasers to a pay-per-use subscription-based model, since the equipment item EQ161 *laser, excimer* is available for purchase and already accounted for under its equipment methodology. A question was raised regarding equipment item ED005 *camera, digital system, 12 megapixel (medical grade)* and what is the typical method to acquire images. There has been a perceptible shift in technology from the use of cameras to cell phones (with an application that inputs directly into the electronic health record). The PE Subcommittee agreed to maintain the direct practice inputs without modification. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

<u>Lactation Care Services (Tab 17)</u>
Suzanne Berman, MD (AAP), Steve Krug, MD (AAP)

In May 2025, the CPT Editorial Panel approved two codes to report lactation care directed by a physician or qualified health care professional (QHP) for the first 30 minutes and each additional 15 minutes thereafter. CPT code 978XX is intended to be used by the supervising physician/QHP to report lactation care services ordered by a physician/QHP and provided by a lactation consultant/counselor in the office or other outpatient setting for a mother-baby dyad. The specialty society surveyed code 978XX for the September 2025 RUC meeting while determining that the new add-on code 978X1 was practice expense only.

978XX *Lactation care directed by a physician or other qualified health care professional, including history, assessment, training, and report; first 30 minutes*
The RUC reviewed the survey results from 131 pediatricians and concurred that the survey respondents overvalued the physician work involved in performing this service. The RUC determined that a direct crosswalk to CPT code 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional* (work RVU = 0.18, 5 minutes intra-service time and 7 minutes total time) appropriately accounts for the physician work involved in this service. The RUC determined a crosswalk code was warranted due to a flawed survey and potential misunderstanding by survey respondents regarding who was performing the service. The specialty clarified that there is physician/QHP supervisory work while the lactation consultant performs the service. This work is

very similar to 99211 in that a physician/QHP provides supervision and guidance to clinical staff, reviews documentation and provides care coordination and develops a treatment plan.

The RUC recommends 5 minutes intra-service time and 2 minutes immediate post-service time for 7 minutes total time to appropriately match the crosswalk code. The RUC questioned whether there is an overlap with Evaluation and Management (E/M) services on the same day. However, the specialty society clarified that the typical patient is seen for a well-child visit during which time the need for lactation care services is identified by the physician/QHP and the mother-baby are seen on a different day by the lactation consultant. The visit is not urgent and therefore does not typically occur on the same day as an E/M but is scheduled thereafter. The lactation consultation is also not intended for the inpatient setting but is typically performed after discharge in the physician office setting. The specialty society further clarified that this new code will typically be reported only once per mother-baby lifetime. The RUC discussed the physician work in the post-service period, which consists of a review of documentation of the lactation consultant (approximately 3 pages), the infant's weight change and the growth chart. A care plan is established and care coordination provided, including ordering durable medical equipment supplies (breast pump and supplies, nipple shield, supplemental nursing system) and/or prescriptions (e.g., for mastitis, yeast infection). The RUC concurred that there is physician work involved, which is similar to care management services.

To justify a work RVU of 0.18, the RUC compared the surveyed code to MPC code 94010 *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation* (work RVU = 0.17, 5 minutes intra-service time and 7 minutes total time), noting a strong comparison with identical intra-service and total times and a nearly identical amount of physician work for the two services. The RUC also compared the surveyed code to MPC code 71046 *Radiologic examination, chest; 2 views* (work RVU = 0.22, 4 minutes intra-service time and 6 minutes total time) and noted that the comparator code involves more physician work and intensity and is therefore appropriately valued higher than the surveyed code. The RUC further noted that these MPC codes appropriately bracket the recommendation.

For additional support, the RUC compared the surveyed code to CPT code 94060 *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration* (work RVU = 0.22, 5 minutes intra-service time and 8 minutes total time), noting the identical intra-service times, yet the comparator code involves slightly more physician work, total time, and intensity, and is therefore appropriately valued higher than the surveyed code.

The RUC concluded that the surveyed code should be valued based on a direct crosswalk for both work RVU and times to CPT code 99211 and agreed the crosswalk value below the survey minimum is appropriate in this instance. **The RUC recommends a work RVU of 0.18 for CPT code 978XX.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs for CPT code 978XX and new add-on code 978X1 which is a practice expense only code. The Subcommittee made a single modification to the inputs to reflect the request for a new clinical staff type for *Lactation Consultant*. The specialty society provided supportive documentation for the new clinical labor type, stating that the lactation consultant does not have to be an RN but must be certified. The specialty society recommended that clinical staff type L051A *RN* be used as a proxy for the *Lactation Consultant* staff type.

The Subcommittee also clarified that the new equipment item *scale, infant, digital, fine gradation* is in the exam room for the entire visit as the baby is weighed multiple times, before and after feedings on each breast. **The RUC recommends the non-facility direct practice expense inputs as modified by the Practice Expense Subcommittee including a request for a new clinical labor type, *Lactation Consultant*.**

X. CMS Request/Relativity Assessment Identified Codes

Arthroplasty – Shoulder (Tab 18)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Paul Lichstein, MD (AAOS)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 23472 as having a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. The RAW concluded that CPT code 23472 represents a site of service anomaly since visits are currently included in the valuation of this service that are not typically occurring. The RAW also worked with the specialty society and identified code 23470 as part of this family of services. The RUC recommended that CPT code 23470 and 23472 be surveyed for September 2025.

23470 ***Arthroplasty, glenohumeral joint; hemiarthroplasty***
The RUC reviewed the survey results from 112 orthopaedic surgeons and determined a direct work RVU crosswalk to CPT code 67107 *Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid* (work RVU= 16.00, intra-service time of 90 minutes, total time of 290 minutes) appropriately accounts for the work required to perform this service, noting that it is below the survey 25th percentile. Both procedures typically involve the same amount of intra-service time, similar complexity, and the same overall amount of physician work. The RUC recommends 43 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 35 minutes immediate post-service time, 0.5x 99238 discharge visit, 1x 99214 and 2x 99213 post-operative office visits, totaling 303 minutes. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit is typical. The 23-hour policy was applied to capture this visit as an additional 10 minutes of same data post-operative time. The specialty society explained that the level of complexity of the problem and the medical decision-making around the medication support a level 4 office visit for the first post-operative visit. The society noted that the surgeon is often prescribing or making decisions around prescribing narcotic and anticoagulation medication at the first post-operative office visit.

The specialty society added that there is no one dominant typical patient for this low volume procedure (as seen in the low percentage of survey respondents that found the vignette to be typical). Other examples of cases treated with this procedure, in addition to glenohumeral joint osteoarthritis typical patient included in the vignette, are after traumatic injury, with avascular necrosis or for osteomyelitis/joint infection.

The current value for 23470 is based on a review during the Harvard study that included responses from 11 general orthopaedic surgeons for intra-service time. The procedure for shoulder hemi-arthroplasty has undergone meaningful changes since 1990, both in technique and in the frequency, it is performed. Modern prostheses are designed with modular systems, allowing surgeons to modify

humeral length, height, offset, and retroversion during the procedure. This helps to better match anatomical variations, restore proper muscle balance, and adjust for bone quality, when compared to earlier less customizable systems. These changes in complexity and modularity are manifest by the typical use of digital templating performed prior to the procedure to assess for several data points and parameters including implant size and length and for humeral head offset, size, thickness, version, and positioning.

Initially, hemi-arthroplasty (HA) had broad indications and was commonly performed. Over time, studies have shown that "anatomic" total shoulder arthroplasty (ATSA) and especially "reverse" total shoulder arthroplasty (RTSA) provide better pain relief and functional outcomes, leading to a shift away from routine HA except in some cases of osteoarthritis, particular fracture scenarios, cases of avascular necrosis, or in younger patients with minimal glenoid wear. ATSA and RTSA yield improved pain and function compared to HA, especially for patients with glenoid-sided arthritic changes. Hemiarthroplasty can lead to glenoid erosion, joint space loss, and subchondral sclerosis, which can complicate or worsen outcomes if later revised to total shoulder arthroplasty. The overall decline in HA is due to advances in total shoulder arthroplasty, but mainly due to increased use of RTSA.

To support the recommended work RVU, the RUC compared the surveyed code to MPC code 19303 *Mastectomy, simple, complete* (work RVUs= 15.00, intra-service time of 90 minutes, total time of 283 minutes) and noted that although both services typically involve the same intra-service time, the surveyed code is a more intense service to perform and typically involves more total time. For additional support, the RUC also compared the surveyed code to CPT code 33956 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older* (work RVU=16.00, intra-service time of 90 minutes, total time of 250 minutes) and noted that both services typically involve the same amount of intra-service time, whereas the reference code has less total time though is more intense to perform. **The RUC recommends a work RVU of 16.00 for CPT code 23470.**

23472 ***Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))***

The RUC reviewed the survey results from 123 orthopaedic surgeons and determined a direct work RVU crosswalk to CPT code 61798 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion* (work RVU= 19.85, intra-service time of 120 minutes, total time of 225 minutes) would be appropriate, noting that it is below the 25th percentile. Both procedures typically involve the same amount of intra-service time. The crosswalked neurosurgery procedure on a complex cranial lesion involves much less total time, though it is a more intense and complex service to perform, offsetting the time difference. The RUC recommends 50 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 120 minutes intra-service time, 35 minutes immediate post-service time, 0.5x 99238 discharge visit, 1x 99214 and 2x 99213 post-operative office visits, totaling 340 minutes. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit is typical. The 23-hour policy was applied to capture this visit as an additional 10 minutes of same data post-operative time. The specialty noted that the level of complexity of the problem and the medical decision-making around the medication support a level 4 office visit for the first post-operative visit. They also explained that the surgeon is often prescribing or making decisions around prescribing narcotic and anticoagulation medication at the first post-operative office visit. The specialty explained that this procedure typically requires 50 minutes of pre-service evaluation time to also sufficiently account for the time needed to perform and review digital templating with computer software prior to

surgery to determine type, size, location, version, and positioning of total shoulder arthroplasty implants and fixation.

The specialty society noted that the typical operative technique for a total shoulder arthroplasty has changed since the last review 10 years ago to a "reverse total shoulder arthroplasty" (RTSA). In RTSA, the normal “ball-and-socket” structure of the shoulder is reversed: the artificial ball is attached to the shoulder blade (glenoid), and the artificial socket is attached to the upper arm bone (humerus). This is the opposite of standard (anatomic) shoulder arthroplasty (ATSA). RTSA allows the large deltoid muscle to power the shoulder and move the arm. RTSA has expanded indications when compared to ATSA.

In 2012, ATSA was the main approach, best suited for patients with isolated osteoarthritis with an intact rotator cuff. RTSA was less commonly performed and was used for more limited indications. Today, RTSA is more widely utilized and preferred for complex cases which include, but are not restricted to, massive rotator cuff tear with or without osteoarthritis, failed previous surgery, deformity from prior fracture, osteoarthritis with reduced glenoid bone stock, and osteoarthritis with poor bone quality. These indications reflect a greater surgical complexity and a broader patient population. The specialty society presented supporting summary claims data that showed that the typical procedure in both the outpatient setting, and the inpatient setting is now performed using the RTSA surgical approach.

Modern RTSA technology and technique have been steadily advancing and now employ a wider variety of implants, materials, and increased modularity. Prosthetics have evolved in the last decade to better mimic anatomy; reduce wear, loosening, or notching; and improve patient function. The surgery often requires management of altered anatomy from prior procedures or trauma, adding complexity compared to primary shoulder arthroplasty on unaltered joints. The specialty also explained that patients who undergo RTSA often have more complex histories (e.g., multiple prior surgeries, chronic soft tissue deficiency, bone loss). RTSA patients present challenging postoperative rehabilitation needs, reflecting both increased surgical and clinical complexity.

To support the recommended work RVU, the RUC compared the surveyed code to top key reference code 23616 *Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement* (work RVU= 18.37, intra-service time of 120 minutes, total time of 413 minutes) and noted that both services typically involve the same amount of intraservice time. Although the reference code involves more total time, it is a much less intense service to perform which was confirmed by the survey respondents (86 percent of those that selected this key reference indicated 27472 was more intense and complex). For additional support, the RUC also compared the surveyed code to MPC code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU= 21.16, intra-service time of 120 minutes, total time of 404 minutes) and note that both services typically involve the same amount of intra-service time, whereas the reference code involve more total time justifying a higher valuation. **The RUC recommends a work RVU of 19.85 for CPT code 23472.**

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.**

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.

Arthroplasty – Hip (Tab 19)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS), Paul Lichstein, MD (AAOS)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 27130 as having a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. The RAW concluded that CPT code 27130 represents a site of service anomaly since visits are currently included in the valuation of this service that are not typically occurring. The RUC recommended that CPT code 27130 be surveyed for September 2025.

27130 ***Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft***
The RUC reviewed the survey results from 238 orthopaedic and hip/knee surgeons and determined a direct work RVU crosswalk to CPT code 67108 *Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique* (work RVU= 17.13, intra-service time of 90 minutes, total time of 295 minutes), noting that it is below the survey 25th percentile. Both procedures typically involve the same amount of intra-service time, similar complexity, and the same overall amount of physician work. The specialty noted and the RUC concurred that the work of 27130 and 27447 total knee replacement requires the same physician time and complexity to perform and therefore should be valued the same.

The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5-99238 discharge visit, 1-99214 and 2-99213 post-operative office visits, for a total time of 305 minutes. The specialty society noted that 15 minutes of positioning time was typical to position the patient supine on a traction table or position the patient in the lateral decubitus. The specialty society noted that the level of complexity of the problem and the medical decision-making around the medication management, support a level 4 office visit for the first post-operative visit. The specialty society noted that the surgeon often prescribes or makes decisions around prescribing narcotic and anticoagulation medication at the first post-operative office visit.

The shift toward value-based alternative payment models has driven significant redesign in the care of total hip arthroplasty patients—producing shorter hospital stays, decreased reliance on post-acute care facilities and reduced hospital readmissions. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit is now typical. The 23-hour policy was applied to capture this visit as an additional 20 minutes of the same data post-operative time.

To support the recommended work RVU, the RUC compared the surveyed code to CPT codes 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU= 17.69, intra-service time of 90 minutes, total time of 362 minutes) and 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)* (work

RVU= 18.00, intra-service time of 90 minutes, total time of 367 minutes). All three codes typically involve the same amount of intra-service time, whereas the reference procedures each involve more total time. The RUC confirmed that these three procedures would have appropriate relativity with one another. **The RUC recommends a work RVU of 17.13 for CPT code 27130.**

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.**

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.

Arthroplasty – Knee (Tab 20)
William Creevy, MD (AAOS), Hussein Elkousy, MD (AAOS)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 27447 as having a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. The RAW concluded that CPT code 27447 represents a site of service anomaly since visits are currently included in the valuation of this service that are not typically occurring. The RAW also worked with the specialty societies and identified code 27446 as part of this family of services. The RUC recommended that CPT codes 27446 and 27447 be surveyed for September 2025.

27447 ***Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)***
The RUC reviewed the survey results from 245 orthopaedic and hip/knee surgeons and determined a direct work RVU crosswalk to CPT code 67108 *Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique* (work RVU= 17.13, intra-service time of 90 minutes, total time of 295 minutes) appropriately accounts for the work required to perform this service, noting that is below the survey 25th percentile. Both procedures typically involve the same amount of intra-service time, similar complexity and the same overall amount of physician work. The specialty society noted and the RUC concurred that the work of 27447 and 27130 total hip replacement require the same physician time and complexity to perform and therefore should be valued the same.

The RUC recommends 40 minutes pre-service evaluation time, 15 minutes pre-service positioning time, 15 minutes pre-service scrub/dress/wait time, 90 minutes intra-service time, 40 minutes immediate post-service time, 0.5x 99238 discharge visit, 1-99214 and 2-99213 post-operative office visits, for a total time of 305 minutes. The specialty society noted and the RUC concurred that 15 minutes of positioning time was typical to account for the time needed to position the patient supine, as well as for applying and confirming the settings for a tourniquet. The specialty society noted that the level of complexity of the problem and the medical decision-making around the medication management, support a level 4 office visit for the first post-operative visit. The specialty society noted that the surgeon often prescribes or makes decisions around narcotic and anticoagulation medication at the first post-operative office visit.

The shift toward value-based alternative payment models has driven significant redesign in the care of total hip arthroplasty patients—producing shorter hospital stays, decreased reliance on post-acute care facilities and reduced hospital readmissions. Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit is typical. The 23-hour policy was applied to capture this visit as an additional 20 minutes of the same data post-operative time.

To support the recommended work RVU, the RUC compared the surveyed code to CPT codes 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU= 17.69, intra-service time of 90 minutes, total time of 362 minutes) and 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)* (work RVU= 18.00, intra-service time of 90 minutes, total time of 367 minutes). All three codes typically involve the same amount of intra-service time, whereas the reference procedures each involve more total time. The RUC confirmed that these three procedures would have appropriate relativity with one another. **The RUC recommends a work RVU of 17.13 for CPT code 27447.**

Affirm RUC Recommendations
The RUC affirms its April 2021 work RVU recommendation of 17.13 for CPT code 27446.

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.**

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>Transcatheter Aortic Valve Replacement (Tab 21)</u>
Vigneshwar Kasirajan, MD (STS), Ed Tuohy, MD (ACC), Jospeh Turek, MD (STS) and Richard Wright, MD (ACC)

CPT codes 33361-33366 were on the New Technology/New Services list and noted in the RUC database as "Do not use to validate physician work" because of the unique co-surgery status for 33361-33366 (-62 co-surgeon modifier is required) and CPT code 33364 did not meet the survey threshold of 30 responses. In April 2025, the Relativity Assessment Workgroup (RAW) reviewed three years of available Medicare claims data (2021, 2022 and 2023). The RUC recommended that these services be surveyed for September 2025. The patient population has changed on who is receiving these services, and it is no longer the sickest, most complicated patients, but will be available to more candidates, and these services may be used to treat aortic regurgitation.

In September 2025, the specialty societies request that these services be referred to CPT to address changes in the approaches utilized for the procedures prior to re-surveying them. As such, the specialty societies did not survey the TAVR codes for the September 2025 RUC meeting and plan to submit a code change application to CPT by the November 3, 2025, deadline for review at the February 2026 CPT meeting. **The RUC agreed and recommended that CPT codes 33361-33366 be referred to the CPT Editorial Panel for the February 2026 meeting.**

Appendectomy (Tab 22)
Charles Mabry, MD (ACS), Don Selzer, MD (ACS), Ketan Sheth, MD (SAGES), Kelly Tyler, MD (ASCRS) and Richard Weiss, MD (APSA)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 44970 *Laparoscopy, surgical, appendectomy* as a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. These services were placed directly on the level of interest form to survey for September 2025. The RAW also worked with the specialty societies and identified codes 44950, 44955 and 44960 as part of this family of services.

In September 2025, the specialty societies indicated that the ACS National Surgical Quality Improvement Program (NSQIP®) and NSQIP® Pediatric database analysis revealed considerable variability in both length of hospital stay and operative time for appendectomy procedures. This is influenced by multiple factors such as surgical approach, patient age, whether the disease was complicated or straightforward, and whether the surgery was performed as an interval appendectomy or for tumor. In light of these findings, the specialty societies indicated that new and revised codes are needed to more accurately describe and differentiate global physician work for these services. The specialty societies indicated they will submit a CPT code change application for the CPT 2028 cycle.

The RUC agreed and recommended that codes 44950, 44955, 44960 and 44970 be referred to the CPT Editorial Panel for revision for CPT 2028, preferably by the May 2026 CPT meeting/September 2026 RUC meeting.

Stereotactic Computer-Assisted Volumetric Navigational Procedures (Tab 23)
Brian Boyce, MD (AAO-HNS), Anthony DiGiorgio, MD (CNS), Hussein Elkousy, MD (AAOS) William Lavelle, MD (ISASS) and Clemens Schirmer, MD (CNS)

In April 2024, CPT code 61783 *Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)* was identified via the high-volume growth screen, with Medicare utilization of 10,000 or more that has increased by at least 100% from 2017 through 2022. In January 2025, the Relativity Assessment Workgroup (RAW) reviewed the action plan for CPT code 61783 and determined that this service was last valued in 2010, and utilization is steadily increasing, thus it should be surveyed with the appropriate family of codes for April 2025. In April 2025, the specialty societies surveyed 61782 and 61783 with the standard ZZZ survey template. However, the specialty societies indicated that there is a distinct and separate pre-service time for these services. The RUC agreed and the specialty societies were allowed to resurvey 61781, 61782 and 61783 with the ZZZ survey template that asks whether pre- or post-time is included in these services. The RUC noted that CPT codes 61781, 61782 and 61783 were originally reviewed as a family at the February 2010 RUC meeting for publication in CPT 2011. CPT codes 61781 and 61783 were valued the same at 3.75 work RVUs and 61782 was valued at 3.18 work RVUs.

Based on 2023 Medicare utilization, CPT code 61781 is performed by neurosurgery (97%), CPT code 61782 is performed by otolaryngology (98%), and CPT code 61783 is performed by neurosurgery (67%) and orthopaedic surgery (32%). For September 2025, the specialty societies that primarily perform these services participated in the survey. Neurosurgery surveyed code 61781, otolaryngology surveyed code 61782 and neurosurgery, orthopaedic surgery, and spine surgery surveyed code 61783.

Family of Services
In April 2025, the specialty societies indicated that CPT codes 61781, 61782 and 61783 are not a family of services as they are reported with distinctly different procedures and should not have been placed for convenience together in the Nervous System/ Skull, Meninges, and Brain/Stereotaxis subsection of CPT. The specialty societies believed that it was not correct to maintain all three codes together in the Nervous System section as established. Specifically, there is a Spine and Spinal Column/Stereotaxis subsection under the Nervous System subsection where code 61783 could have been located, or it could also have been placed in the Musculoskeletal System/Spine subsection. The specialty societies also question whether 61782 is correctly placed in the Nervous System section instead of in the Musculoskeletal System/Head subsection, closer to the procedures that 61782 is typically reported.

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

ZZZ Survey Template
CPT codes 61781, 61782 and 61783 were all surveyed for pre- and post-service time in 2010, and each included 15 minutes of pre-service time. In April 2025, CPT codes 61782 and 61783 were surveyed this time with the standard ZZZ survey template, which specifies the ZZZ global period as a *code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-service time and in some instances the pre-and post-service time)* and only allows entry of intra-service time. In rare circumstances, specialties may provide justification and request that a ZZZ survey with pre- and post-service time be conducted. The specialty societies are requesting to resurvey these services with the pre/post ZZZ survey template.

The specialties indicated that they believe the pre-service time that was captured in the 2010 valuation remains an integral part of this work for these services. Pre-service time is essential and inseparable from these services. The RUC confirmed that this pre-service time does not overlap with the time included in the base procedures these ZZZ global codes are reported with. For CPT code 61782, this work includes critical, physician-performed tasks directly related to the implementation and use of stereotactic computer navigation. These include an in-depth discussion with the patient about the rationale for the navigation system, its role in enhancing surgical precision, and its implications for surgical complexity and duration. This is particularly relevant in cases involving altered anatomy or proximity to critical structures. In addition, the surgeon must initiate, configure, and verify the navigation system, including hardware setup, image review in multiple planes, software validation, and procedural planning based on the individual patient's anatomy and pathology. These are non-delegable, case-specific activities that are essential to the safe and effective use of this advanced technology and therefore justify discrete pre-service time beyond what is included in the base code.

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

The RUC determined that the specialty societies may survey 61781, 61782 and 61783 with the amended ZZZ survey template that specifically asks the respondent whether pre- and post-service time is associated with these add-on services for the September 2025 meeting.

61781 ***Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 55 neurosurgeons and determined the current work RVU of 3.75, which is below the survey 25th percentile (3.77), accounts for the work required to perform this service. The RUC recommends 17 minutes pre-evaluation time and 30 minutes intra-service, totaling 47 minutes. As it is typical for many neurosurgical procedures to have pre-service time due to the high intensity and complexity of the procedure, the RUC continued to recommend pre-service time for this add-on service. The specialty societies indicated, and the RUC agreed that the pre-service time for the navigation for the intradural cranial, CPT code 61781, requires more pre-service time than the navigation for the extradural cranial, CPT code 61782, because the accuracy of the navigation is dependent on how much time the physician spends on ensuring that the star fixation, registration, and all other elements that allow one to perform navigation with commensurate accuracy are set up. Thus, the time required to perform these activities, not just from the extracranial surface but to the intracranial space, is why the respondents for the intracranial navigation procedure (61781) indicated that they spent 6 more minutes.

CPT code 61781 is an add-on service that is reported with intracranial procedures. Pre-operative CT and/or MRI images are loaded into an image guidance system, and the patient is then connected via a patient marker and the patient's external anatomy is traced to allow for proper registration. The system then matches the 3D model of the patient obtained by tracing the imaging, allowing the surgeon the ability to use various instruments to point and display on the scan where that instrument is specifically located in the patient.

The RUC compared the surveyed code to the second key reference service 61797 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)* (work RVU = 3.48, 30 minutes intra-service and total time) and determined that these services both require the same intra-service time. However, the surveyed code requires 17 minutes pre-service evaluation time, thus it is appropriately valued higher than CPT code 61797.

For additional support the RUC referenced MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service and total time) and CPT code 67335 *Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)* (work RVU = 3.23, 30 minutes intra-service time and total time), which requires similar physician work and time, therefore maintains relativity of this service. **The RUC recommends a work RVU of 3.75 for CPT code 61781.**

61782 ***Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 108 otolaryngologists and determined that a work RVU of 2.11 appropriately accounts for the work required to perform this service based on a direct crosswalk to 93587 *Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (eg, from*

innominate vein) (List separately in addition to code for primary procedure) (work RVU = 2.11 and 16 minutes intra-service and total time). The RUC recommends 11 minutes of pre-service time and 16 minutes of intra-service time, totaling 27 minutes for CPT code 61782. The RUC noted that this service currently includes pre-service time due to the high intensity and complexity of the procedure, thus, the RUC continued to recommend pre-service time for this add-on service.

CPT code 61782 is an add-on code that is used with endoscopic sinus surgery codes. Pre-operative CT and/or MRI images are loaded into an image guidance system, and the patient is then connected via a patient marker and the patient's external anatomy is traced to allow for proper registration. The system then matches the 3D model of the patient obtained by tracing the imaging, allowing the surgeon the ability to use various instruments in the nose to point and display on the scan where that instrument is specifically located in the patient. The accuracy is usually within a millimeter. Stereotactic computer-assisted navigation is often used in cases that are distorted by previous surgery such as extensive nasal polyps, tumors, or disease abutting the skull base, internal carotid artery, optic nerve, among other critical structures. In these cases, navigational guidance is critical to aid in the identification of these structures to avoid complications such as blindness, cerebrospinal leaks, other intracranial injuries, and damage to the carotid, resulting in life-threatening bleeding or strokes.

The RUC compared the surveyed code to the top key reference code 19294 *Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)* (work RVU = 3.00, 40 minutes intra-service time and total time) and determined the surveyed code requires less physician work and time and thus is appropriately valued lower. The RUC also compared the surveyed code to the second top reference code 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.00, 30 minutes intra-service time and total time) and determined the surveyed code is somewhat more intense and complex requiring more psychological stress and mental effort and judgment, thus valued higher.

For additional support, the RUC referenced MPC codes 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 15 minutes intra-service and total time) and 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and 30 minutes intra-service and total time). The RUC also referenced CPT code 20702 *Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)* (work RVU = 2.50, 25 minutes intra-service time and 32 minutes total time), which requires more time, but the surveyed code is somewhat more intense and complex to perform. The RUC determined that a work RVU of 2.11 supported relativity among similar services. **The RUC recommends a work RVU of 2.11 for CPT code 61782.**

61783 ***Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 70 neurosurgeons, orthopaedic surgeons, and spine surgeons, and determined the current work RVU of 3.75, which is between the survey 25th percentile (3.42) and survey median (4.08), appropriately values this service and maintains relativity within the

family. The RUC recommends 15 minutes pre-service evaluation time and 30 minutes intra-service, totaling 45 minutes. As it is typical for many neurosurgical procedures to have pre-service time due to the high intensity and complexity of the procedure, the RUC continued to recommend pre-service time for this add-on service.

CPT code 61783 is an add-on service that is reported with arthrodesis and other spinal procedures. Pre-operative CT and/or MRI images are loaded into an image guidance system, and the patient is then connected via a patient marker and the patient's external anatomy is traced to allow for proper registration. The system then matches the 3D model of the patient obtained by tracing the imaging, allowing the surgeon the ability to use various instruments to point and display on the scan where that instrument is specifically located in the patient.

The specialty societies indicated that the current work RVU of 3.75 supports the time and intensity of this service. The typical patient with multi-level deformity involves more than solely hooking up the navigation and synchronizing with a scan. It involves multiple pieces of new technology where the navigation accuracy needs to be precise due to the location of working along the spine. The success of the procedure is dependent on the navigation planning, thus, the pre-service evaluation time is more intense than other services. Additionally, the software has improved and is faster, but because the physician must process multiple forms of information for more complicated surgeries with more deformity corrections, it is certainly more intense, even though the time itself has not necessarily changed.

The RUC compared the surveyed code to the top key reference service 61797 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)* (work RVU = 3.48, 30 minutes intra-service and total time) and determined that these services both require the same intra-service time. However, the surveyed code requires 15 minutes pre-service evaluation time, thus is appropriately valued higher than CPT code 61797.

For additional support, the RUC referenced MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13- and 40-minutes intra-service and total time) and CPT code 67335 *Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)* (work RVU = 3.23, 30 minutes intra-service time and total time), which requires similar physician work and time. The RUC determined that a work RVU of 3.75 supported relativity among similar services. **The RUC recommends a work RVU of 3.75 for CPT code 61783.**

Practice Expense

In April 2025, the Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for CPT code 61782 and made a single modification. Invoices were submitted for three new supplies: *single use instrumentation wire, patient tracker* and *adhesive pad*. The Subcommittee amended the patient tracker inputs to correct the price of the new supply item since it is available in a 5-pack, and the adhesive in a 10-pack, but only one of each is used. The specialty societies also recommended four new equipment items: *navigation system, pointer shell universal mounts, medical cart without monitor* and *registration pointer*. The RUC noted the equipment *service contract standard* was not included because maintenance, such as a service contract, is already included in the calculation of the cost per minute. In September 2025, the PE Subcommittee re-reviewed the direct practice expense inputs for CPT code 61782 and made no modifications. It was acknowledged that non-facility PE

inputs are being added for this ZZZ code. This includes the addition of the intra-service staff time to support the physician during the procedure (16 minutes), the supplies needed for the image guidance, and the equipment needed for the image guidance which have the default formula applied to them. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies for CPT code 61782. For CPT codes 61781 and 61783, the RUC recommends no direct practice expense inputs as these are facility-based add-on services.**

Laminectomy (Tab 24)
Anthony DiGiorgio, MD (CNS), Hussein Elkousy, MD (AAOS), William Lavelle, MD (ISASS) and Clemens Schirmer, MD (CNS)

In April 2025, the Relativity Assessment Workgroup (RAW) identified CPT code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* as a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. These services included in the level of interest form to survey for September 2025. The RAW also worked with the specialty societies and identified codes 63045, 63046 and 63048 as part of this family of services. In the Final Rule for 2014, CMS also determined that codes 63045 and 63046 were part of the same family. When 63047 and 63048 were surveyed alone, CMS valued them as interim and requested the whole family be surveyed together (63045, 63046, 63047 and 63048) and reviewed by the RUC. These services were surveyed for September 2025.

63045 ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical***
The RUC reviewed the survey results from 94 physicians for CPT code 63045 and determined that a work RVU of 17.69, slightly below the survey 25th percentile work RVU of 18.00, appropriately accounts for the work required to perform this service. The recommended work RVU is based on a direct crosswalk to key reference service CPT code 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU = 17.69, 90 minutes intra-service time and 362 minutes total time). The RUC recommends 40 minutes pre-service evaluation time, 25 minutes positioning time, 15 minutes scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99214 and 2-99213 post-operative visits, totaling 384 minutes. CPT code 63045 is primarily performed in the inpatient hospital setting (84% based on 2023 Medicare claims data).

The specialty society indicated that the additional pre-service positioning time is necessary to place serial compressive devices. As well as leads for intraoperative neuromonitoring, when used, are positioned and secured, and baseline neuromonitoring values are obtained prior to positioning. After ventilatory and vascular access is accomplished, the patient's head is secured with the three-point head holder and the patient is carefully rolled off of the hospital bed and onto the operating room table, maintaining neutral lordosis or slight flexion. The head is affixed to the bedframe using the head holder. The patient is secured in the prone position with pressure points padded. Arms are positioned such that they are secured yet anesthesia can access vascular ports. The table is positioned on an incline. The shoulders may be taped down caudally, to help with intraoperative imaging of the

cervical levels, with care taken to avoid pressure on the brachial plexi. Neuromonitoring recording, when used, is repeated to verify that there is no change in recordings after patient positioning. Additional skin taping may be undertaken to manage excess skin folds as common in the posterior neck.

The specialty societies noted that the median intra-service time required to perform this service has decreased, however, the intensity and complexity have increased. The procedure described by code 63045 has seen changes over time regarding patient complexity, technology, and surgical practice, though the core surgical goals remain similar. There has been a trend toward performing CPT code 63045 on more complex patients. Patients undergoing cervical laminectomy increasingly have more complex degenerative cervical disease and may present with advanced age and comorbidities. A retrospective database analysis demonstrated that the procedure is often performed on older patients, who may have multiple cervical levels affected and less ideal cervical sagittal balance, making surgery and recovery more challenging. This is evidenced by the increasing rate of conversion to fusion following cervical laminectomy versus laminoplasty.[1] Laminoplasty and minimally invasive approaches have evolved as alternatives, aiming to preserve cervical motion, reduce structural instability, and lower the risk of revision and fusion. However, cervical laminectomy remains important for multilevel decompression and in challenging cases, especially when other anatomical or disease factors preclude less invasive methods.[2] Surgery may be more technically challenging due to patient factors (older, sicker, more anatomical variation) and increasing expectations for preserving motion and alignment. Therefore, this service is performed faster than when it was last surveyed. However, it is more intense and complex due to the increased complexity of the patient.

The RUC compared CPT code 63045 to the top key reference service 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time and 355 minutes total time) and the second top key reference code and crosswalk code, 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU = 17.69, 90 minutes intra-service time and 362 minutes total time). The surveyed code and the key reference services require the same intra-service time and similar total time. The intensity and complexity measures for the surveyed code, compared with the key reference services, support the relativity of the procedures. The surveyed code is technically challenging due to narrow spaces, and the need for precision to avoid nerve/spinal cord injury, but there is less risk to visceral/vascular neck structures than the anterior approach associated with codes 63075 and 22554.

For additional support the RUC referenced CPT code 34001 *Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision* (work RVU = 17.88, 90 minutes intra-service time and 384 minutes total time) and CPT code 50040 *Nephrostomy, nephrotomy with drainage* (work RVU = 16.68, 90 minutes intra-service time and 405 minutes total time) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 17.69 for CPT code 63045.**

[1] Liu AM, Gausper A, Etigunta SK, Tuchman A, Mikhail C, Skaggs D, Chan V. Rate of Conversion to Fusion Following Cervical Laminectomy Versus Laminoplasty: A Retrospective Analysis of 4,406 Patients. Global Spine J. 2025 Jun 6. Epub ahead of print.
[2] Weinberg DS, Rhee JM. Cervical laminoplasty: indication, technique, complications. J Spine Surg. 2020 Mar;6(1):290-301.

63046 ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic***

The RUC reviewed the survey results from 94 physicians for CPT code 63046 and determined that a work RVU of 17.14, which is below the survey 25th percentile work RVU of 18.00, appropriately accounts for the work required to perform this service. The recommended work RVU is based on a direct crosswalk to CPT code 46710 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* (work RVU = 17.14, 90 minutes intra-service time and 370 minutes total time). The RUC recommends 40 minutes pre-service evaluation time, 25 minutes positioning time, 15 minutes scrub/dress/wait time, 90 minutes intra-service time, 30 minutes immediate post-service time, 1-99232, 1-99231, 1-99238, 1-99214 and 2-99213 post-operative visits for CPT code 63046. CPT code 63046 is primarily performed in the inpatient hospital setting (80% based on 2023 Medicare claims data).

The specialty society indicated that the additional pre-service positioning time is necessary to place serial compressive devices. Leads for intraoperative neuromonitoring, when used, are positioned and secured, and baseline neuromonitoring values are obtained prior to positioning. After ventilatory and vascular access is accomplished, the patient's head is secured with the three-point head holder and the patient is carefully rolled off of the hospital bed and onto the operating room table, maintaining neutral lordosis or slight flexion. The head is affixed to the bedframe using the head holder. The patient is secured in the prone position with pressure points padded. Arms are positioned such that they are secured yet anesthesia can access vascular ports. The table is positioned on an incline. The shoulders may be taped down caudally, to help with intraoperative imaging of the thoracic levels, with care taken to avoid pressure on the brachial plexi. Neuromonitoring recording, when used, is repeated to verify that there is no change in recordings after patient positioning. Additional skin taping may be undertaken to manage excess skin folds as needed.

The specialty societies noted that the median intra-service time required to perform this service has decreased, however, the intensity and complexity have increased. The procedure described by code 63046 has experienced some evolution over time, similar to cervical and lumbar decompression procedures. Patients undergoing thoracic decompression procedures like CPT code 63046 tend to be more complex now than a decade ago due to an aging population with more severe degenerative spinal conditions, multilevel disease, and sometimes prior spine surgeries requiring more extensive decompression. Indications have broadened, including cases with increased spinal instability, fractures, and severe degenerative disc disease, which can complicate surgery relative to earlier years. Newer surgical technologies such as spinal navigation, minimally invasive retractors, ultrasonic bone scalpels, and intraoperative imaging systems have been increasingly incorporated into thoracic spine surgery and laminectomies, adding technical complexity. Therefore, this service is performed faster than when it was last surveyed. However, it is more intense and complex due to the increased complexity of the patient.

The RUC questioned why the thoracic laminectomy, CPT code 63046, is less work than the cervical laminectomy, CPT code 63045, even though the survey respondents indicated the exact same time. The specialty societies indicated that the cervical laminectomy requires more physician work intensity due to the risk of ischemia and deformity associated with performing that service.

The RUC compared CPT code 63046 to the top key reference service 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time and 355 minutes total time) and CPT

code 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU = 17.69, 90 minutes intra-service time and 362 minutes total time). The surveyed code and key reference services require the same intra-service time and similar total time. The intensity and complexity measures for the surveyed code compared with the key reference services support the relativity of the procedures. The thoracic spinal cord is less forgiving than cervical or lumbar regions, as there is much less space before neurological injury can occur. Access is technically more challenging due to the rib cage, narrower spinal canal, and regional vascular structures. There is also an increased risk of spinal cord injury with small surgical errors resulting in CPT code 63046 less commonly performed than cervical or lumbar decompression.

For additional support the RUC referenced CPT code 50040 *Nephrostomy, nephrotomy with drainage* (work RVU = 16.68, 90 minutes intra-service time and 405 minutes total time) and CPT code 34001 *Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision* (work RVU = 17.88, 90 minutes intra-service time and 384 minutes total time) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 17.14 for CPT code 63046.**

63047 ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar***

The RUC reviewed the survey results from 94 physicians for CPT code 63047 and determined that the current work RVU of 15.37, which is below the survey 25th percentile work RVU of 17.00, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes pre-service evaluation, 20 minutes positioning, 15 minutes scrub/dress/wait, 90 minutes intra-service time, 50 minutes immediate post-service time, 0.5-99238, 1-99214 and 2-99213 post-operative visits. CPT code 63047 is no longer primarily performed in the inpatient hospital setting (46% based on 2023 Medicare claims data). Survey respondents indicated, and the RUC concurred, that an overnight stay and same-day post-operative hospital visit is typical. The 23-hour policy was applied to capture this visit as an additional 20 minutes of same data post-operative time.

The specialty society indicated that the additional pre-service positioning time is necessary to place serial compressive devices. Leads for intraoperative neuromonitoring, if used, are positioned and secured, and baseline neuromonitoring values are obtained prior to positioning. (Intraoperative monitoring, when performed, is not reported by the operating surgeon.) Once anesthesia is satisfied with the ventilatory and vascular access, the patient is carefully rolled off of the hospital bed and onto the operating room table; the neck is protected and secured, the head is affixed to the bed frame using the head holder. The patient is secured in the prone position with pressure points padded. Arms are positioned such that they are secured yet anesthesia can access vascular ports.

The specialty societies provided detailed information on the level of post-operative visits (1-99314 and 2-99213) in the summary of recommendation rationale. The first post-operative visit is a level 99214 with moderate medical decision making to address symptom review and detailed neurological examination. At this visit, evaluation of the nerve and spinal cord recovery are assessed after the lumbar laminectomy to track progressive restoration of neurological function consistent with spinal cord and nerve healing. The second and third post-operative visits are level 99213 with low medical decision making to address pain management, physical therapy management, suture/staple/drain (when applicable) removal, neurological examination, and care plan changes.

In January 2013, when this service was last surveyed and reviewed by the RUC, the specialty societies indicated that they considered that the work of these procedures had increased due to the changing patient characteristics. With the growing frequency of non-surgical spine intervention, patients are increasingly presenting for surgery having had prior procedures and studies are beginning to show an increase in the work and length of stay for these patients. Many Medicare and private payors are beginning to require longer waiting periods before spine surgery and during this time patients often receive other interventions, making the patients who do receive surgery more difficult. At that time, the specialty societies decided to recommend the current value rather than the survey 25th percentile, although monitoring the trend in patient characteristics was considered warranted as the work involved in this procedure has already changed since 2005 and is likely to continue to evolve as the patients become more complex.

Additionally in 2013, several reviewers noted that there was considerable evidence that the recommended work RVU (15.37) may have been too low and that an increase may have been warranted. The specialty societies agreed with the commenters but noted the current literature did not support a request for compelling evidence. However, the societies expected that there may be compelling evidence in the near future of a change in work and, therefore, may nominate the codes for re-review at that time.

In 2025, the specialty societies noted that the procedure described by CPT code 63047 experienced some evolution over time, similar to the cervical and thoracic decompression procedures. Patients undergoing lumbar decompression procedures, such as CPT code 63047, tend to be more complex now than a decade ago due to an aging population with more severe degenerative spinal conditions, multilevel disease, and sometimes prior spine surgeries requiring more extensive decompression. Indications have broadened, including cases with increased spinal instability, fractures, and severe degenerative disc disease, which can complicate surgery relative to earlier years. Newer surgical technologies such as spinal navigation, minimally invasive retractors, ultrasonic bone scalpels, and intraoperative imaging systems have been increasingly incorporated into lumbar spine surgery and laminectomies, adding technical complexity.

The RUC compared CPT code 63046 to the top key reference service 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU = 19.60, 90 minutes intra-service time and 355 minutes total time) and CPT code 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU = 17.69, 90 minutes intra-service time and 362 minutes total time). The surveyed code and key reference services require the same intra-service time of 90 minutes. The surveyed code is less intense and complex than the anterior approach for cervical discectomy or cervical fusion. The lumbar spine is generally more accessible with a larger spinal canal space than the thoracic or cervical regions, although obesity, scar tissue from prior surgery, or severe stenosis can increase complexity. The lumbar region requires microsurgical precision to avoid nerve root or dural injury but is less complex than anterior approach fusion or tumor resections. Therefore, the intensity and work RVU of the survey code is appropriately less than the key reference services.

For additional support the RUC referenced CPT code 63620 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion* (work RVU = 15.60 and 90 minutes intra-service time) and determined that maintaining the current work RVU supported relativity among similar services.

The RUC determined that maintaining the current work RVU of 15.37 for CPT code 63047 is appropriate given the increased intensity and complexity due to the change in patient population and new technology incorporated in lumbar spine surgery and laminectomies, and the perceived undervaluation noted during the 2013 valuation. **The RUC recommends a work RVU of 15.37 for CPT code 63047.**

63048 ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 94 physicians who perform this service and determined that the current work RVU of 3.47 and 45 minutes of intra-service time appropriately accounts for the work required to perform this service. The current value is below the survey 25th percentile work RVU of 5.27. The RUC noted that the lumbar laminectomy/facetectomy, foraminotomy CPT code 63047 is typically reported with this add-on service.

The RUC compared the surveyed code to top key reference service 63052 *Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 4.25 and 45 minutes intra-service time) and determined that the surveyed service requires slightly less work to perform since it does not occur during posterior interbody arthrodesis.

For further support, the RUC compared the surveyed service to MPC codes 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service time) and 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and 30 minutes of intra-service time) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 3.47 for CPT code 63048.**

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 this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

<u>Injection Anesthetic Agent (Tab 25)</u>
Raissa Villanueva, MD (AAN), Elizabeth Volpert, DNP (ANA) and Meghan Ward, MD (AAN)

In April 2025, the RUC reviewed 64400 as identified via the "Do not use to validate physician work" flag. In 2018 for CPT 2020, the RUC flagged 64400 because the RUC recommended work RVU of 1.00 was based on the 25th percentile work RVU of the top performing specialty, neurology. For

2020, CMS did not accept the RUC recommendation and valued 64400 lower at 0.75. The RUC recommended to survey 64400 and its family of services for September 2025.

64400 ***Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)***
The RUC reviewed the survey results from 48 neurologists and nurse practitioners and determined the current work RVU of 0.75, which is slightly below the survey 25th percentile (0.80), appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes pre-evaluation time, 1 minute scrub/dress/wait time, 6 minutes intra-service time and 5 minutes immediate post time, totaling 19 minutes. The RUC noted that this service has a median of 2 units of service typically reported, however the multiple procedures payment reduction (MPPR) applies and reductions for each second and subsequent service will occur.

The RUC compared the surveyed code to the top key reference service 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscles* (work RVU = 0.75, 10 minutes intra-service and 27 minutes total time) and determined that while CPT code 64400 requires less intra-service time to perform, it is more intense and complex than CPT code 20553. The longer pre-service and intra-service time for CPT code 20553 may be necessary for performing the multiple injections (3 or more as described by the descriptor for code 20553), but the anatomical locations of the injections, in soft tissues, make it less intense than CPT code 64400. Further, CPT code 64400 requires localizing specific nerves, whereas trigger point injections involve areas of muscle, therefore, identifying the injection sites is more intense for CPT code 64400. The relative intensity of the surveyed code to the reference code is reflected in the responses to the intensity questions in the survey, where 79% of the respondents indicated that the surveyed code is somewhat to much more intense and complex to perform.

For additional support the RUC referenced MPC codes 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 5 minutes intra-service and 21 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) and 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.00, 7 minutes intra-service and 17 minutes total time) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 0.75 for CPT code 64400.**

64405 ***Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve***
The RUC reviewed the survey results from 59 neurologists and nurse practitioners and determined that the survey 25th percentile work RVU of 0.84 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes pre-evaluation time, 1 minute scrub/dress/wait time, 6 minutes intra-service time and 5 minutes immediate post time, totaling 19 minutes. The RUC noted that this service has a median of 2 units of service typically reported, however the multiple procedures payment reduction (MPPR) applies and reductions for each second and subsequent service will occur.

The specialty societies noted, and the RUC agreed that an injection in the greater occipital nerve (CPT code 64405) compared to an injection in the trigeminal nerve (CPT code 64400) requires slightly higher complexity to perform. The location of the injections for the greater occipital nerve for CPT code 64405 requires specific anatomic landmarks to identify the nerve, as the injection can be in

proximity to the occipital artery, explaining the higher intensity of CPT code 64405 compared to 64400.

The RUC compared the surveyed code to the top key reference service 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscles* (work RVU = 0.75, 10 minutes intra-service and 27 minutes total time) and determined that while CPT code 64405 requires less intra-service time to perform, it is more intense and complex than CPT code 20553. The longer pre-service and intra-service time for CPT code 20553 may be necessary for performing the multiple injections (3 or more as described by the descriptor for code 20553), but the anatomical locations of the injections, in soft tissues, make it less intense than CPT code 64405. Further, CPT code 64405 targets a single nerve with proximity to an artery requiring aspiration and potential adjustment of the needle, therefore the intensity is higher than multiple injections into muscle and/or soft tissue. The relative intensity of the surveyed code to the key reference service is reflected in the responses to the intensity questions in the survey, where 58% of the respondents indicated that the surveyed code is somewhat to much more intense and complex to perform.

For additional support the RUC referenced MPC codes 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) and 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.00, 7 minutes intra-service and 17 minutes total time) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 0.84 for CPT code 64405.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. The Subcommittee noted that the Multiple Procedure Payment Reduction (MPPR) rule applies and would address any duplication, thus they maintained the inputs as submitted. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

XI. Research Subcommittee (Tab 26)

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

- **Review of May 19th Research Subcommittee Conference Call Report**

The Research Subcommittee reports from the May 19th conference call included in Tab 26 agenda materials were approved without modification.

- **Use of Electronic Health Record Data to Validate Time Data**

Nate Apathy, PhD, Assistant Professor of Health Policy & Management at the University of Maryland School of Public Health, provided a presentation on the use of EHR audit log data to estimate service/procedure time. Dr. Apathy went into detail on what EHR audit log data captures and makes it distinct from other data sources. He provided an example of audit log data which aligns with a time motion study of an individual office visit. He also gave suggestions for potential pilot studies that could be relevant to the RUC process.

Dr. Apathy explained that EHR audit log data is a record of activity inside the EHR. He noted that major clinical events and their timestamps do not require the audit log. Rather, these activities can be

captured from other datasets (ie placing an order, completion of an imaging or lab test, completion of clinical documentation, completion of patient registration, etc.). Dr. Apathy noted that, for the sample AMA RUC use case, these interstitial events are more likely to be demarcations of pre/intra/post-service time, and they capture micro-activity across the entire clinical team relatively easily. Dr. Apathy showed the audit log data from an example office visit that is paired with a recording of the visit that is publicly available: https://observer.med.upenn.edu/dataset/explore. For this example case, the audit log data underrepresented the actual physician time by 8%.

Dr. Apathy explained that audit log data is systematically collected for all visits and can be organized by visit, patient, and/or user. He noted that the audit log data definitionally captures all activity in a given patient's chart and this would be its core use case for researchers.

Dr. Apathy noted that it is challenging to account for workflow, staffing, and teamwork differences across physicians and organizations, though it is possible to partially mitigate this challenge by relying on the law of large numbers. For example, researchers could extract audit logs for observed procedures and larger (but not directly observed) samples of the same procedure. Dr. Apathy also noted it is difficult (if not impossible) to capture cognitive intensity of work; this is a major potential issue for primary care specialties in particular. He also noted that audit log data can underestimate active time for activities that predominantly involve non-logged behavior (e.g., reading & writing notes).

Potential Pilot Studies
Dr. Apathy suggested two potential pilot studies that may be useful to the RUC process. One involved selecting a specific RUC clinical staff or physician time standard, such as the physician post-service time standard for the operative note or clinical staff standard for vital signs. This pilot would involve identifying the specific logged events that correspond with this activity for a sample of surgical procedures and determining the start and stop time of these specific activities in the log. The second pilot study concept involves selecting a small sample (5-10) of CPT codes, conducting direct observation of a small sample of these services in person and extracting the audit log data for these procedures. Next would involve matching the observation data to the audit logs for the observed sample to construct rules for start and end points. These rules could be applied to a larger non-observed audit log dataset at scale and used to compare to survey data.

Doctor Weida, the Chair of the Research Subcommittee, thanked Dr. Apathy for the informative presentation and noted that the Research Subcommittee would further discuss potential pilot studies.

- **Maternity Care Services: Custom Survey Instruments and Vignette Request**
  American College of Obstetricians and Gynecologists
  American Nurses Association

At the September 2025 CPT Editorial Panel meeting, the Panel approved significant changes to the Maternity Care Services (MCS) CPT codes. The societies submitted a request to the Research Subcommittee to review the following five proposed custom survey templates and vignette changes. All surveys would include the full CPT language as a reference for the survey respondents.

The Research Subcommittee approved customizations to the Maternity Care Services survey templates, summarized as follows:

For the full list of changes in detail, reference the September 2025 Research Subcommittee Report

- **Labor Management Survey (59XX1-59XX4):** The societies proposed to use the February 2022 inpatient and observation care services survey instrument to survey the new labor management codes and collect total time on day of encounter, with some additional modifications. The Subcommittee discussed the proposed changes and concurred they were appropriate. The Subcommittee concurred that the changes would be clear that these services are for all physicians/QHPs in the same group practice.

- **Delivery Survey (59XX5, 59XX6, 59414, 59300, 59X11, 59X12, 59XX7 and 59XX8):** The surveying societies plan to use the standard 000 survey template with a few modifications. A custom question was included to confirm that Nurse Midwives were eligible to complete the survey for 59X12. A question was added questions about which provider typically performs 59X11 and 59X12. The data from these questions will help ensure appropriate accounting for pre/post times. Pre-service evaluation time questions (day proceeding and day of) were removed for 59XX5 and 59XX6. CPT defines "*Delivery care begins when labor is complete (presenting part of the fetus is visible and firmly rimmed by the vaginal introitus) or interrupted (eg, arrest of labor is diagnosed and subsequent decision for cesarean delivery is made).* Pre-service evaluation time is included in the labor management codes for vaginal births (59XX5 and 59XX6).

- **Cesarean Hysterectomy (C-Hyst) Survey (59XX9):** The surveying societies plan to use the standard 000 survey template with a few modifications. A custom instruction as added to "Please complete this survey as the surgeon called in to perform the subtotal or total hysterectomy during the same operative session as the cesarean delivery." The day preceding pre-eval time question was removed. During the discussion, the vignette was discussed as well and the Research Subcommittee and the societies agreed to a modification.

  The Research Subcommittee agreed to the following modified vignette for 59XX9:

  > **59XX9 Subtotal or total hysterectomy after cesarean delivery**
  > **Research-Approved Vignette:** A 34-year-old female, gravida 3, para 3 with known placenta accreta spectrum (PAS) has intractable bleeding during her cesarean delivery and requires a hysterectomy.

- **Antepartum/Postpartum Survey (59320, 59325, 59412, 59871, 59X10 and 59160):** The surveying societies plan to use the standard 000 survey with the only change being to change hospital to "hospital/birthing center" for question 2C for 59412 and 59X10. Separately, the societies also submitted a proposed vignette for CPT code 59030, which currently does not have a vignette in the RUC database. **The Research Subcommittee approved the vignette as submitted:**

  > **CPT Code 59030 Fetal scalp blood sampling:**
  > **Research-Approved Vignette:** A 33-year-old female, gravida 1, para 0 at 38 weeks gestation, is in the active phase of labor. The fetus has persistent minimal variability requiring fetal scalp blood sampling.

The RUC approved the Research Subcommittee Report.

XII. Professional Liability Insurance (PLI) Workgroup (Tab 27)

Doctor Bradly Marple, Chair, provided the report on the Professional Liability Insurance (PLI) Workgroup. Instead of an in-person meeting, the Workgroup held their meeting via conference call on August 13, 2025, to align with the CY 2026 Medicare Physician Payment Schedule Proposed Rule comment period.

- **Proposed Specialty Overrides for Low Volume Services**

The standard process for deriving professional liability insurance (PLI) RVUs uses the most recent year's Medicare claims data to determine a specialty-weighted liability insurance premium as one of the main input into the PLI RVU formula. On occasion, a few erroneous claims with an incorrect CPT code number are present in the data CMS uses to derive PLI and indirect PE RVUs (meaning for those services the wrong specialty was used to derive the PE and PLI RVUs for the impacted code). To mitigate this issue, beginning in 2018, CMS first implemented a policy recommendation from the RUC to use single specialty override assignments for the assigned PLI risk premiums and indirect practice expense for very low volume services (those with an average of less than 100 Medicare utilization over the past 3 years). The current list, which includes over 2,000 codes, is available in the Proposed Rule addenda files.

For CY2026, AMA RUC staff performed an analysis to identify all eligible codes and put together a list of potential specialty overrides for each newly eligible service. Following the completion of the analysis and initial review, AMA Staff circulated the list to all RUC participants soliciting specialty society feedback on whether the suggested specialty override would be appropriate for each of the newly eligible service and received robust feedback.

The PLI Workgroup reviewed the updated proposed list of low specialty overrides for eligible services. The proposed list included 72 newly added services. **The PLI Workgroup approved the proposed list of Expected Specialty Recommendations for Low Volume Codes for CY2026 NPRM Comment as included in the agenda materials with the 4 modifications recommended by societies. The updated document was sent to CMS as part of the RUC comment letter.**

- **Review of Draft RUC Comment Letter Section on PLI**

The Professional Liability Insurance (PLI) Workgroup was asked to review and approve the PLI portion of the RUC's draft comment letter on the CMS *Proposed Rule* on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2026.

The draft PLI section of the letter offers input on the imputation methodology used by CMS and the vendor and also provided the updated low volume single specialty override recommendations. The Workgroup agreed that the draft content prepared by AMA RUC Staff was appropriate and did not have any suggested changes.

The RUC approved the PLI Workgroup Report.

XIII. Practice Expense Subcommittee (Tab 28)

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

At the April 2025 meeting, the PE Subcommittee considered Tab 7 *Transoral Oropharyngeal Procedures* and noted that the history of the components of EQ137 *instrument pack, basic ($500-$1499)* and EQ138 *instrument pack, medium ($1500 and up)* may not be well understood by current participants. The PE Subcommittee expressed the need to understand the background related to the formation of these packs. Accordingly, at the September 2025 meeting, the PE Subcommittee reviewed the informational Staff Note and discussed the twenty-year history of the surgical instrument packs. The recommendation for a Basic Surgical Instrument Package - $500 with cleaning time of 10 minutes and a Medium Surgical Instrument Package - $1,500 with cleaning time of 15 minutes was approved in March 2003. This action established standard surgical instrument packages with an approximate cost, recognizing that each society may have their own set of surgical instrument packs with different instruments.

At the September 2025 meeting, the PE Subcommittee considered two tabs performed with moderate sedation, Tab 05 *Intraosseous Fiducial Marker Placement* and Tab 07 *Sacroiliac Joint Arthrodesis*. This requires review and confirmation that duplicate PE inputs do not exist; in doing so, the Subcommittee questioned the rationale for including a sterile gown but no mask in the moderate sedation pack (SA044). The PE Subcommittee expressed the need to understand the background related to the formation and composition of this pack. **The PE Subcommittee agreed that AMA staff will research the issue of SA044 *pack, moderate sedation* to share the history regarding how this pack was developed.**

The RUC approved the Practice Expense Subcommittee Report.

XIV. Relativity Assessment Workgroup (Tab 29)

Amr Abouleish, MD, Chair of the Relativity Assessment Workgroup, provided the Workgroup report to the RUC. Dr. Abouleish indicated the Workgroup reviewed action plans for approximately 70 codes for 12 different screens and the recommended actions are outlined in the full report attached to these minutes.

The Workgroup also discussed three possible new screens: RUC review > 20 years ago with Medicare utilization over 1 million screen, high IWPUT screen and CMS Inpatient Only List for identification of site of service anomalies.

RUC review > 20 years ago with Medicare utilization over 1 million screen
For the RUC review > 20 years ago with Medicare utilization over 1 million screen, the Workgroup identified two codes and **requested that the specialty societies submit action plans for codes 17110 and 99291 for review at the January 2026 meeting.**

High IWPUT
For September 2025, AMA staff examined the data and identified 37 codes with an IWPUT greater than 0.14 and 2023 Medicare utilization over 1,000. Eight of these services were either reviewed via the last identification of this screen or were recently reviewed for CPT 2026. The Workgroup noted

that ZZZ and 000-day global codes should also be excluded as they were not included in the first iteration of the high IWPUT screen. After removing the ZZZ and 000-day global codes, 9 codes remained, all which were reviewed since the first iteration of this screen in 2008, and the RUC applied a thorough review of the IWPUT during those valuations. **The Workgroup determined rerunning the high IWPUT did not identify any potentially misvalued services to examine further.**

CMS Inpatient Only List – Site of Service Anomaly Identification

In April 2025, during new business at the RUC meeting, another potential screen was identified to investigate. A RUC member requested that the RAW look at the annual CMS inpatient only list for services performed in the outpatient setting. Annual review of the data instead of three years may promptly confirm site of service accuracy. The Chair of the RAW stated that the original intent of using three years of outpatient data was to ensure that there was truly a shift in site of service from inpatient to outpatient. However, in using this method, a few codes under review at this September 2025 meeting were delayed in review as the removal from the inpatient only list led to an immediate transition to outpatient. It was suggested that if the data is overwhelmingly outpatient after one year, it would indicate that an immediate re-review should occur as the service had clearly transitioned to outpatient This item was referred to the RAW for further discussion at the September 2025 meeting.

In July 2025, in the Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule for 2026, CMS proposed to eliminate the entire Inpatient Only List over a 3-year period.

In September 2025, the Workgroup discussed the pending CMS proposal to phase out the CMS inpatient only list. The Workgroup would like to discuss further the concept of using some threshold (eg, 60% outpatient) to determine that the codes should be re-reviewed after one year of claims data versus waiting for three years of data to confirm that >50% of services are reported outpatient. CMS decision to remove or retain the inpatient list will also be available before the January 2026 meeting. **The Workgroup determined that it would continue this discussion at the January 2026 meeting.**

The RUC approved the Relativity Assessment Workgroup Report.

XV. New/Other Business (Tab 30)

- A RUC member requested that the Administrative Subcommittee review the compelling evidence guidelines which are currently identified by non-numeric bullets and change them to numeric values. This would allow the specialty to refer to the applicable compelling evidence standard by number (eg, 5b). Further, the RUC member requested that the Subcommittee review and clarify the compelling evidence standard of flawed methodology. **This item has been referred to the Administrative Subcommittee for further discussion.**

- A RUC member requested review of the RUC's Confidentiality Agreement to be in line with the recent revisions by the CPT Editorial Panel. **This item has been referred to the Administrative Subcommittee.**

- A RUC member requested that CPT codes that have Audiology as a clinical staff direct practice expense be reviewed by the Relativity Assessment Workgroup (RAW). Audiology has been able to independently bill Medicare since 2009 and, therefore, should no longer be accounted for in the direct practice expense inputs as clinical staff. Further, at the same time as this review, the

RAW should check for other qualified health care professionals to ensure that time is counted in the work component and not the clinical staff PE inputs. It was further clarified by the PE Chair that under no circumstance can individuals who separately bill Medicare be included under direct practice expense. **This item has been referred to the Relativity Assessment Workgroup.**

- Two RUC members spoke to process improvements to promote efficient deliberations by the RUC, including increased engagement of the primary reviewers alongside the presenters. This could include topics discussed during pre-facilitation. Finally, it was observed that the RUC may wish to do less facilitation on challenging issues during full committee discussions.

The RUC adjourned at 11:35 AM CT on Saturday, September 27, 2025.

AMA/Specialty Society RVS Update Committee Meeting

September 25, 2025

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

RUC Chair Report

Ezequiel Silva III, MD, Chair

Conference Etiquette

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

Meeting Confidentiality

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

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

Lobbying Policy

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

Professional.

Ethical.

Welcoming.

Safe.

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

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

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

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

Professional.

Ethical.

Welcoming.

Safe.

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

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

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

Financial Disclosures

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

CPT Editorial Panel

- Lawrence Simon, MD – CPT Panel Member
- Timothy Swan, MD – CPT Panel Member

Centers for Medicare & Medicaid Services

- Stefanie Fischell, MD – Medical Officer
- Edith Hambrick, MD – Medical Officer
- Emily Yoder – Deputy Director, Div of Practitioner Svcs

Centers for Medicare & Medicaid Services

(attending virtually)

- Hannah Ahn, PhD
- Perry Alexion, MD
- Lindsey Baldwin
- Erick Carrera, JD
- Zehra Hussain
- Sarah Leipnik
- Mikayla Murphy
- Jake Quinton, MD
- Julie Rauch
- Terry Simananda
- Pam West

U.S. Government Accountability Office (GAO)

- Lisa Minich, PhD
- Kelly Krinn, MPP
- Leslie Gordon

Virtual Attendees:

- Greg Giusto
- Xiaoyi Huang
- Dani Sosa
- Mela Brown

Office of Inspector General

(attending virtually)

- Laura Behnke
- Vlada Hutton
- Janet McLeod
- Nicki Stauffacher

Medicare Payment Advisory Commission (MedPAC)
(attending virtually)

- Rachel Burton, MPP – Principal Policy Analyst

Special Guest

- Nate C. Apathy, PhD – Assistant Professor of Health Policy & Management, The University of Maryland School of Public Health
- EHR data availability
- www.nateapathy.com

AMA CEO, Executive Vice President

- John Whyte, MD, MPH

New RUC Member

- Mark T. Villa, MD – American Society of Plastic Surgeons (ASPS)

New RUC Alternate

- Christopher Shale, MD – American Society of Plastic Surgeons (ASPS)

Departing RUC Participants

- Jeffrey P. Edelstein, MD (AAO)
  - RUC Member 2019-2025
  - RUC Alternate 2009-2019

- Charles Mabry, MD (ACS)
  - 30 years of service in the RUC process!

- Catherine Hill
  - Specialty Society Staff since 1998 (AANS/CNS 2001-2025)

Thank you and Farewell!

Reviewer Guidelines

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

Procedural Issues: RUC Members

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

Procedural Issues: Voting

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

Procedural Issues: Voting

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

Procedural Issues

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

Procedural Issues: RUC Ballots

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

Procedural Issues: New Business

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

Research Subcommittee

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

Meeting with CMS Re: Proposed Rule

- Aug 27, 2025 met with Chris Klomp, Deputy Director and Administrator
- Discussion was consistent with RUC comments submitted on the Proposed Rule for 2026

Director’s Report

Sherry L. Smith, MS, CPA

Physician Payment Policy & Systems

RUC Appointments and Nominations

- RUC Member reappointment/appointments letters
- Primary care rotating seat memo
- Internal medicine rotating seat letters
- Due to Sherry.Smith@ama-assn.org by November 14, 2025
- Rotating seat elections will occur at the January 14-17, 2026 RUC meeting

RUC Database – 2025 v 2.0

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

RUC Process Webinars

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

Upcoming RUC Meetings

RUC Recommendation Due Date	RUC Meeting	Location	CPT Cycle
Dec 9, 2025	Jan 14-17, 2026	Los Angeles, CA	CPT 2027
Mar 31, 2026	Apr 23-25, 2026	Chicago, IL	CPT 2028
Aug 25, 2026	Sep 24-26, 2026	Chicago, IL	CPT 2028

CME for RUC Meeting Participation

- Physicians can earn up to **32.00** 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 3, 2025**.
- Once you've successfully completed the evaluation, a certificate will be automatically available on **October 17, 2025**, in the "Transcript" section of your AMA Ed Hub account.

AMA Staff Assistance

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

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

Vote to Approve April 2025 RUC Meeting Minutes

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CPT Editorial Panel Update to September 2025 RUC Meeting

Lawrence M. Simon, MD, FAAP
CPT Editorial Panel Member

CPT Panel Meeting Activity – May 2025

RUC Referrals Reviewed at the May 2025 Panel Meeting:

- Decompression Procedure-Delete 62287 (Tab 12)
- Femoral Osteoplasty-Delete 27468 (Tab 16)
- Rotational Vestibular Assessment (Tab 49)

CPT Panel Meeting Activity – September 2025

- **RUC Referrals Reviewed at the September 2025 Panel Meeting:**
  - Osteotomy Guideline Revisions, Spine 22210-22216 (Tab 7)
  - Central Venous Catheter Insertion Services (Tab 22)- withdrawn
  - Prostate Biopsy Services (Tab 29)
  - MRA-Head, Neck (Tab 38)
  - Biofeedback Training (Tab 48)
  - Speech-Language Pathology Services (Tab 52)

September 2025 Panel Meeting

92 Code Change Applications (CCAs) Submitted

Notable agenda items:

- 8 Digital medicine related CCAs
- 28 Category III code applications

See following slides for details regarding:

- Prostate Biopsy Service (Tab 29)
- Maternity Care Services (Tab 30)

Prostate Biopsy Services (Tab 29)

- Stakeholders expressed confusion with previous descriptors regarding number/type of biopsies. Concern for inconsistent reporting/miscoding.
- Changes considered include:
  - Replace “sextants” with “regions” to simplify terminology.
  - Codes 5XX00–5XX03 now cover all regional/systematic biopsies.
  - Clarify use of fusion-targeting (MRI-US) and in-bore CT/MRI guidance.
  - Add-on codes (+5XX07, +5XX10) specify additional lesions.
  - Delete codes (5XX08, 55706).
- Coding clarifies biopsy reporting and aligns with current clinical practice.

Maternity Care Services (Tab 30)

- Stakeholder concerns regarding current maternity code set:
  - Lack sufficient granularity to match contemporary practice and quality reporting standards.
  - Limited ability to study outcomes, address maternal morbidity/mortality, and design accurate payment models—particularly impacting rural practices.
- Proposed revisions provide additional granularity to support quality care and stab match contemporary practice patterns:
  - Antepartum visits & transfers from rural to tertiary care
  - Granular codes for inductions & prolonged labor E
  - Expanded postpartum monitoring codes (hemorrhage, cardiac, mental health)

CPT Ad Hoc Workgroups

Maternity Care Services Workgroup

- Co-Chairs: Padma Gulur, MD; Timothy L. Swan, MD
  - Code change application from May 2025 CPT Editorial Panel Meeting postponed time certain (September 2025) with specific recommendations.
  - The workgroup met on May 28 and again on June 3 to address the Panel's directives.
  - Extensive edits were made at these meetings to both address Panel recommendations and to further clarify Guidelines and Introductory Language.
  - New CCA submitted for the September 2025 CPT Editorial Panel meeting (Tab 30).
  - No substantive advisor or interested party comments received. Most specialty societies supported this new proposal.

CPT Ad Hoc Workgroups

Value Based Care Services Workgroup

- CCA submitted (Tab 95) for the September 2025 CPT Editorial Panel meeting:
  - Revisions to the guidelines to expand the members of the care team whose time can be included in the overall time of the service, provided the care team member is under the direction of a physician or other QHP.
  - Addition of clarifying language on the type of supervision of the care team that is required.
  - Expansion of services to indicate that electronic means are included.
- Phase 2 charge finalized:
  - In alignment with the insights received from the comprehensive market feedback and analysis presented to the Panel, the AMA CPT Value-Based Care Workgroup is tasked with advancing the CPT code set to reflect innovations in value-based care. The Workgroup will guide efforts to modernize coding structures, such as episode-based models, to align with contemporary care delivery systems.

CPT Ad Hoc Workgroups

Digital Medicine Coding Committee (DMCC)

Co-Chairs: Richard Frank, MD, PhD/Mark Synovec, MD

- The workgroup has virtually met frequently since the May CPT Editorial Panel Meeting, both as an internal workgroup and hosting stakeholder calls.
- After much discussion, a code change application (CCA) (not up for Panel vote) was submitted for the September CPT Editorial Panel meeting to allow both written and open comments from additional specialty societies and interested parties.
- **Next steps**: Continue open dialogue at the September Panel meeting and submit a CCA for February 2026.

February 2026 Panel Meeting

- The next Panel meeting is February 5-7, 2026 (Thursday-Saturday) Palm Springs, CA
- **The next application submission deadline is November 3, 2025.**

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FIRST COAST SERVICE OPTIONS

Contractor Medical Director Updates

Janet I. Lawrence, MD, MS, FACP

Upcoming Local Coverage Determinations (LCD's)

- Allergy Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) -Finalizing
- Comment Period Closed for the Following
  - DL38378 Transurethral Waterjet Ablation of the Prostate
  - DL39756 Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancer (NMSC)
  - DL40261 Peripheral Nerve Block Procedures (will replace existing LCD)
  - DL33952 Temporary Nontherapeutic Ambulatory Cardiac Monitoring Devices (will replace Cardiac Event Detection)
  - Botulinum

The End

- That's all for Now
- Stay Tuned

AMA
AMERICAN MEDICAL ASSOCIATION

Washington Report
September 2025

Jennifer Hananoki, Director, Federal Affairs

AMA Comments: 2026 Medicare Physician Payment Schedule Proposed Rule

AMA Comment Letter and Press Release

"In submitting comments today on the 2026 Medicare Physician Fee Schedule, the American Medical Association (AMA) offered to work with the Centers for Medicare & Medicaid Services (CMS) on policy changes that aim to preserve private practice and maintain access to health care…

The AMA noted that two CMS proposals, however, inadvertently go in the opposite direction of bolstering private practice…

The AMA looks forward to continuing the dialogue to ensure that the policy recommendations make Medicare work for our patients and physicians."

Medicare Conversion Factors

Proposed 2026 Medicare Conversion Factors (CFs)							
	2025 CFs	APM or Non APM Update Factor (1.0075 or 1.0025)	CY 2026 RVU Budget Neutrality Adjustment (1.0055)	CY 2026 2.50 Percent Increase (1.025)	Anesthesia Only PE and PLI Adjustment	Proposed 2026 CFs	Percentage Changes
APM QP	$32.3465	$32.5891	$32.7683	$33.5875	N/A	$33.5875	3.84%
Non-APM QP	$32.3465	$32.4274	$32.6057	$33.4209	N/A	$33.4209	3.32%
Anesthesia APM QP	$20.3178	$20.4702	$20.5828	$21.0973	$20.6754	$20.6754	1.76%
Anesthesia Non-APM QP	$20.3178	$20.3686	$20.4806	$20.9926	$20.5728	$20.5728	1.26%

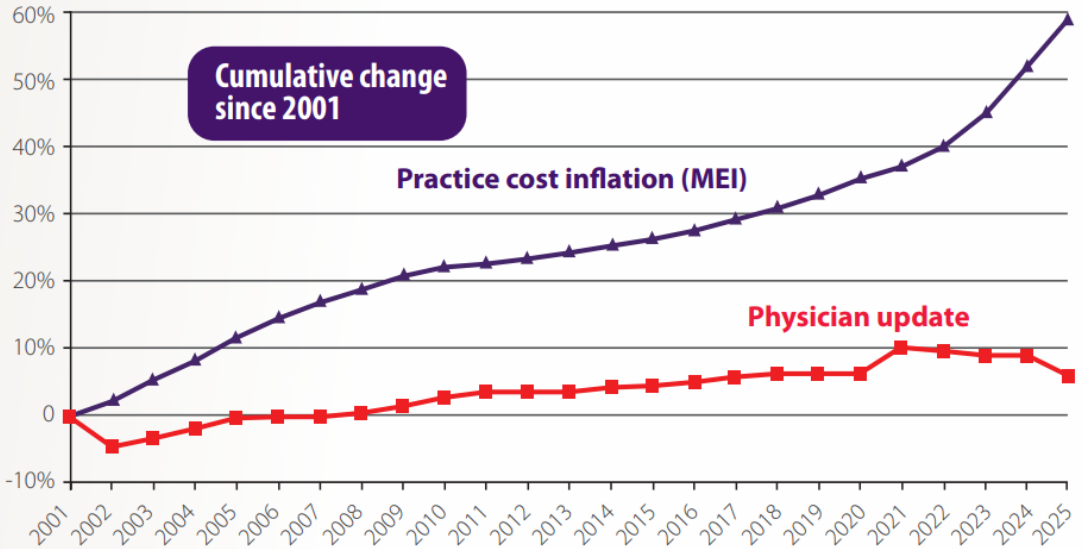
AMA Comments: Permanent Updates Needed

- The AMA appreciates that Congress provided a one-year 2.5 percent update to 2026 Medicare physician payments.
- Despite temporary updates in four of the last five years, Medicare physician payment has continued to erode as economic pressures on physician practices, including rising costs of rent, wages, supplies, and administrative burdens, have intensified.
- The Trump Administration should support any congressional action to enact inflation-based updates for physician payments, such as the provision tied to the MEI that was in the House-passed reconciliation bill.

Medicare physician payment continues to fall further behind practice cost inflation.

Medicare updates compared to inflation in practice costs (2001–2025)

Adjusted for inflation in practice costs, Medicare physician payment **declined 33%** from 2001 to 2025.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

Updated Jan. 2025

AMA AMERICAN MEDICAL ASSOCIATION

AMA | Physicians' powerful ally in patient care

Patient Access at Risk

"This larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals."

- Medicare Payment Advisory Commission (MedPAC)

"Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

- Medicare Trustees

Practice Expense – Site-of-Service Differential

- CMS proposes to reduce the work RVU input for the facility indirect PE RVU formula to 50 percent of the amount used for non-facility PE RVU computation
  - CMS is concerned that the current indirect PE methodology may incentivize care in higher-cost settings
  - CMS believes Medicare is making duplicative payments for physicians' practice expenses under MPFS and facility payment system
- The AMA agrees that payment should be accurate across sites of service and independent physician practice must remain financially viable.
- However, we are concerned about unintended consequences of this proposal.
- The AMA urges CMS to work with us to consider the new 2024 AMA PPI Survey results more fully, which includes updating the PE/HR groupings and specialty data from the 2024 AMA Physician Practice Information Survey.

Efficiency Adjustment

- CMS proposes to decrease the work RVUs and/or physician intra-service time for 95% of physician services by -2.5% and to apply additional reductions every three years.
  - Exemptions for 389 codes including time-based services, E/M, care management, maternity care, and services on the telehealth list
- This cut is based on the last 5 years' productivity adjustments in the MEI
- CMS' rationale:
  - Physician time is inflated with criticism of utilizing physician surveys to estimate physician time and a call for other time data to augment survey data
  - Concern about the timeliness of review of individual services, resulting in unaddressed potential efficiencies due to changes in clinician expertise, workflows and technology
  - "Passive devaluation" of E/M and general goal of increasing payment for primary care services

AMA Comments

- The AMA agrees with CMS' goal of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care payment is adequate.
- The AMA recommended that alternative solutions be considered to accomplish these objectives, including:
  - Consider ensuring that higher volume codes be reviewed on a more frequent basis
  - Continue to support the use of surveys to ensure the clinical expertise of physicians and other health care professionals is respected and utilized in establishing work RVUs and the RUC will utilize additional time data sources to augment the physician surveys
  - Implement a correction to the utilization assumptions for G2211, leading to a positive $1 billion budget neutrality adjustment to the Medicare conversion factor

Combined Impact of Efficiency Adjustment and Practice Expense Site-of-Service Differential

There are more than two million new cancer diagnoses each year, yet 37% of oncologists face notable cuts of 10-20%.

Four million cataract surgeries are performed in the U.S. each year, yet 49% of ophthalmologists face cuts.

Maternal health deserts are spreading across the U.S., but 37% of obstetricians and gynecologists face cuts.

Americans depend on preventive medical services to maintain good health, yet more than 56% of internists face cuts of 5% or more.

As we enter respiratory virus season, 80% of infectious disease physicians face cuts of 5% or more.

Telehealth

- The AMA recommends that CMS:
  - Work with Congress to permanently extend Medicare telehealth policies;
  - Finalize its proposals to permanently lift the frequency limits on telehealth hospital and nursing facility visits and allow virtual direct supervision except for services with a 10- or 90-day global period;
  - Maintain or expand the ability for teaching physicians to provide virtual supervision of residents in metropolitan as well as non-metropolitan areas;
  - Finalize its proposal to streamline the process for adding services to the Medicare Telehealth List; and
  - Permanently remove the requirement that physicians report their home address.

Additional Key Topics

- CMS proposed to accept 89% of the AMA/Specialty Society RVS Update Committee (RUC) recommendations for new/revised CPT codes and codes identified via the RUC's potentially misvalued services process.
- AMA reiterated strong support for the longstanding RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate codes and transparency pricing of these supplies.
- AMA urged CMS to implement the RUC's recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits and office visits be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day.

Merit-based Incentive Payment System (MIPS)

2026 MIPS Proposals and AMA Comments

- AMA supports CMS' proposals to:
  - Maintain the performance threshold to avoid a penalty at 75 points from 2026 through 2028
  - Fine tune attribution for the Total Per Capita Cost measure but maintains this measure is holding physicians accountable for costs outside their control
  - Establish a two-year, informational-only feedback period for new cost measures

2026 MIPS Value Pathways (MVPs)

- CMS proposed 6 new MVPs and reiterated it plans to move to mandatory MVPs in the future
    - Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, Vascular Surgery
- AMA encourages CMS to incentivize MVP reporting and continues to oppose mandating it.
- AMA also urged CMS to rescind or postpone mandatory subgroup reporting for multi-specialty practices to participate in MVPs.

2023 MVP Data and Current Survey

- 1.26% of MIPS eligible clinicians received a MIPS score through an MVP
  - 98 groups, 5 subgroups, and 83 individuals.
- Of the 12 different MVPs available in 2023, more than half of the entities participated in two: the Cancer Care MVP and the Anesthesia MVP.
- Although the Wellness MVP had the third largest number of clinicians involved (902), this was based on the participation of just six groups.
- MVP Adoption Survey – CMS is seeking input and awarding Improvement Activity credit for completing the 10-minute survey

2024 MIPS Final Scores Released

- CMS released 2024 MIPS final scores and performance feedback
- 2024 final scores impact your Medicare Part B payments in 2026
- If there are errors, submit a targeted review request (or appeal)
- More information from CMS:
  - 2024 MIPS Performance Feedback FAQs
  - 2024 Targeted Review User Guide

Alternative Payment Models and CMMI Models

2026 APM Proposals and AMA Comments

- AMA urged CMS to adopt its proposal to add an individual level calculation *in addition to* APM Entity-level calculations for purposes of making QP and Partial QP determinations starting with the 2025 performance year, rather than the 2026 performance year.
- QP thresholds have increased significantly this year from 50 to 75 percent of payments and 35 to 50 percent of patients.
- Advanced APM lump sum bonuses also expired at the end of the 2026 payment year (which is based on participation in 2024).

Medicare Shared Savings Program ACOs

- AMA recommends exceptions for ACOs in rural or underserved areas and those serving medically or socially complex patients to CMS' proposal to reduce the time allowed in one-sided risk from 7 to 5 years
- AMA supports:
  - Flexibilities for new ACOs to meet 5,000 assigned patient minimum
  - Expansion of the extreme and uncontrollable circumstance policies for ACOs to obtain relief from performance requirements to include a cyberattack.
  - Allowing mid-year participant list changes in change-of-ownership scenarios.

Ambulatory Specialty Model (ASM)

- New mandatory payment model for 7 specialties that treat patients with heart failure or low back pain in certain areas between 2027 and 2031
    - Anesthesiology, cardiology, interventional pain management, pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation
- Structured like MIPS and adjusts payments by +/- 9% up to +/- 12%
- Pros:
    - AMA has been urging CMMI to develop specialty models for > 10 years
    - Independent practices can participate; not limited to hospitals or ACOs

ASM Opportunities for Improvement

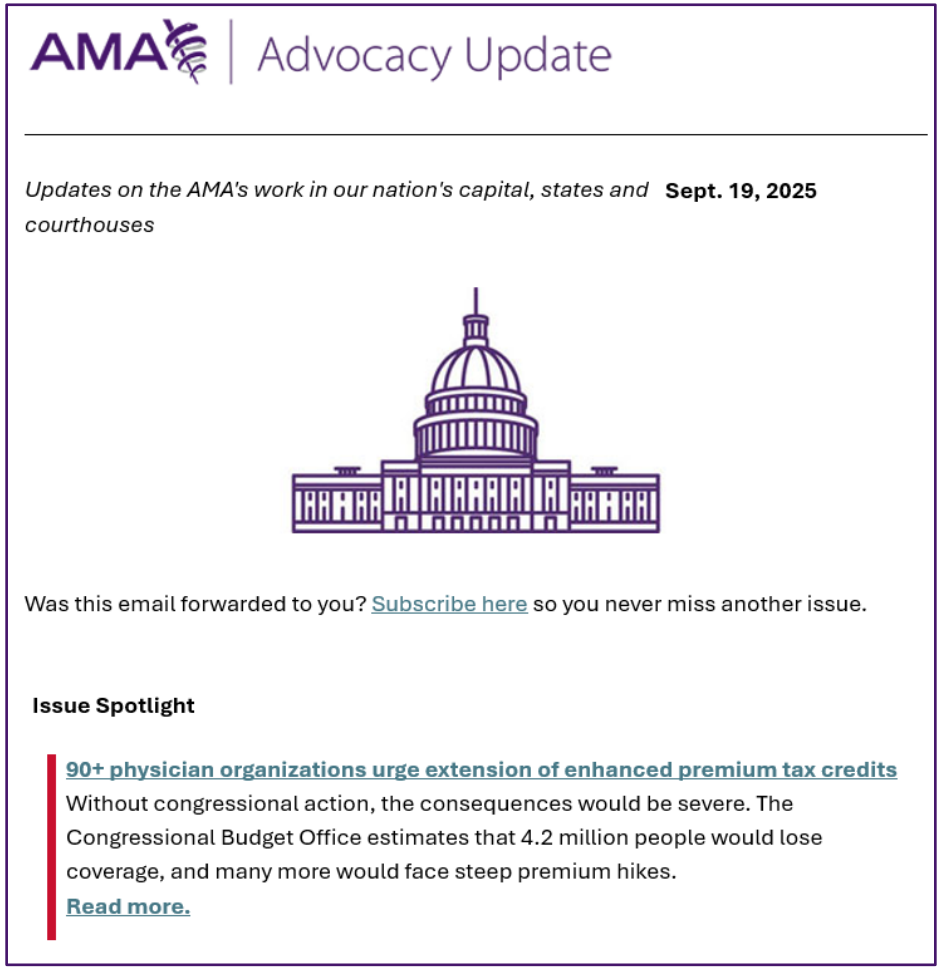
- The AMA strongly urged CMS to redesign ASM as a voluntary model.
- CMS should also set a performance standard in advance instead of using a “tournament” approach.
- CMS should increase the patient threshold from 20 patients with heart failure or low back pain a year.
- CMS should redistribute 100% of funding for payment adjustments and not just 85% of it, which leads to most physicians facing penalties.
- Steep penalties could lead private practices to seek to join a larger practice or become employed.

Wasteful and Inappropriate Service Reduction Model (WISeR) Model

- January 1, 2026 to December 31, 2031 in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.
- Requires prior authorization or pre-payment review for certain services (e.g., skin and tissue substitutes and cervical fusion)
- Vendors will utilize AI and human reviews to make coverage determinations
- “Gold carding” for physicians who meet certain criteria
- AMA urged CMS to pause implementation, make participation voluntary, ensure guardrails for AI, increase transparency, and reduce administrative burden

Stay Connected

- AMA Medicare Physician Payment Schedule webpage
  - Summary of proposed rule
  - RUC infographic
- AMA Advocacy Update
  - Subscribe for weekly newsletter on key federal and state information
- Fix Medicare Now
  - Resources, grassroots campaigns to preserve patient access to care by passing inflation-based Medicare updates for physicians



AMA | Advocacy Update

Updates on the AMA's work in our nation's capital, states and courthouses **Sept. 19, 2025**

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Issue Spotlight

90+ physician organizations urge extension of enhanced premium tax credits
Without congressional action, the consequences would be severe. The Congressional Budget Office estimates that 4.2 million people would lose coverage, and many more would face steep premium hikes.
Read more.

Physicians' powerful ally in patient care

MPFS Spending and Utilization 2019-2025

RUC Meeting September 25, 2025

Apoorva Rama, PhD
AMA Economics Director

Topics Covered

- Focus on Medicare Physician Payment Schedule (MPFS) services
- Broad measures of MPFS spending and utilization (2019-2025 Q1)
  - Type of service, place of service, specialty
  - Telehealth
- Select New Codes (2024-2025 Q1)
  - Add-on for complex/continuous Office E/Ms (G2211)
  - Advanced Primary Care Management Services (G0556, G0557, G0558)
  - Add-on for Infectious Disease Hospital or Observation E/Ms (G0545)
  - Transfer of care for surgical codes (Modifier 54)
  - Artificial Intelligence (75580, 92229)

Medicare 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

Medicare Environment

- Traditional Medicare enrollment was 34 million in 2023.
  - Declined by 11% from 2019 to 2023.
  - Compared to 41% growth in Medicare Private Plan enrollment.
- Traditional Medicare made up 48% of Medicare Spending in 2023.
  - Compared to 61% in 2019.
- MPFS made up 13% of Medicare Part B spending in 2024.
  - Compared to 20% in 2019.

Source: 2025 Medicare Trustees Report. Additional data was obtained through direct correspondence with CMS NHE Health Expenditures Team and Martin et al. (2025).

Claims Data

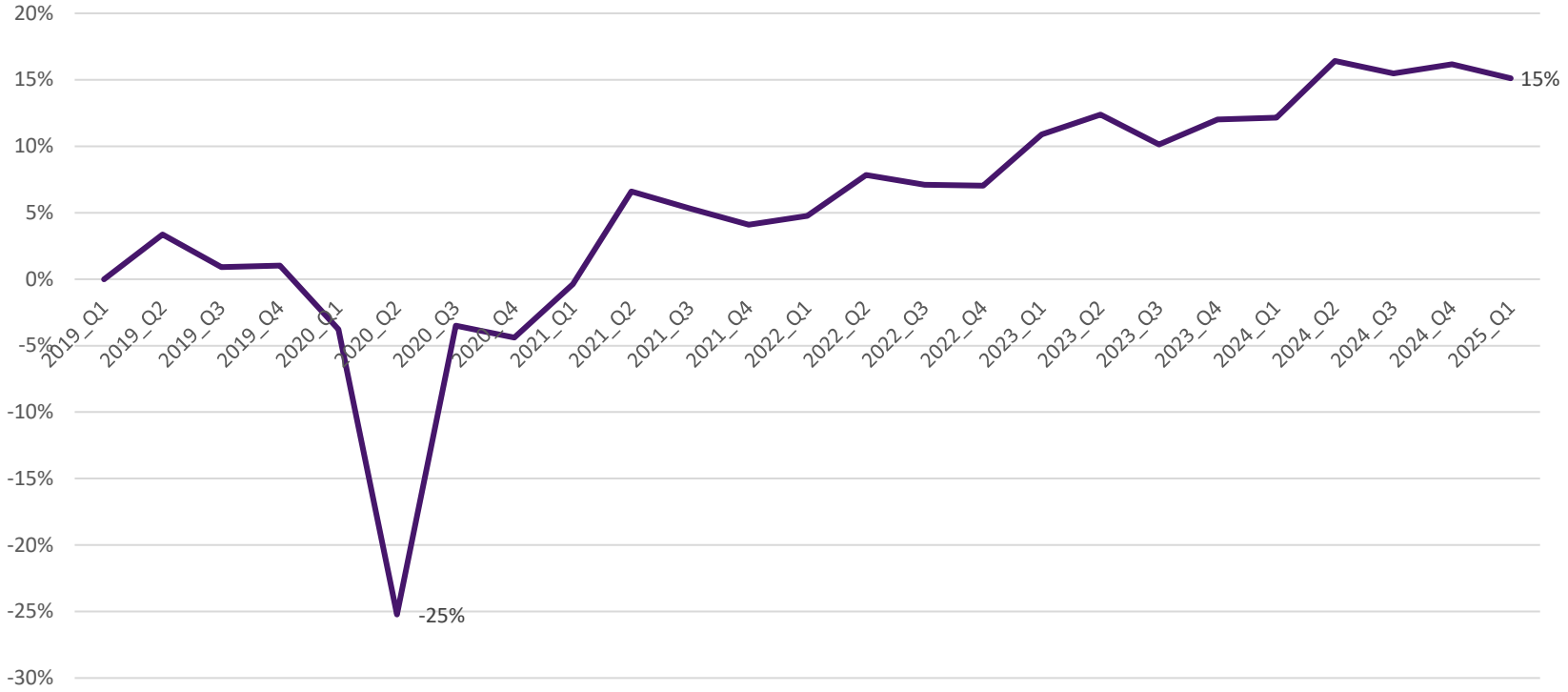
Individual claims data for a 5% sample of Medicare FFS beneficiaries

- Quarterly data files are available through **2025 Q1.**
- These data reflect approximately a 93% completion rate.
  - Note: Data based on claims for 100% of Medicare FFS beneficiaries will be available soon and used to update the RUC database through 2024.
- Results are scaled to reflect the Part B FFS population.

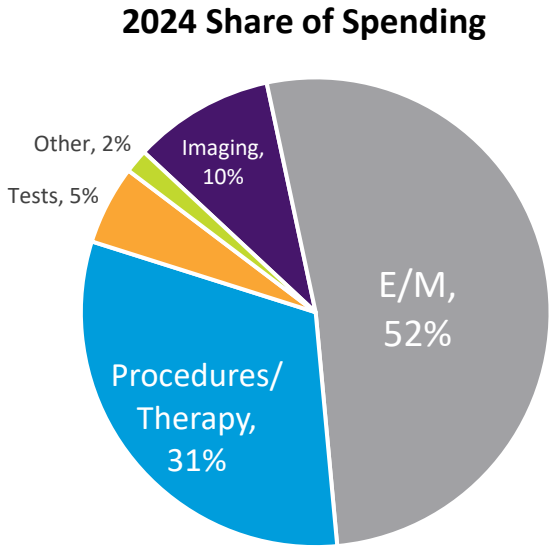
MPFS
Spending and Utilization
2019 to 2025 Q1

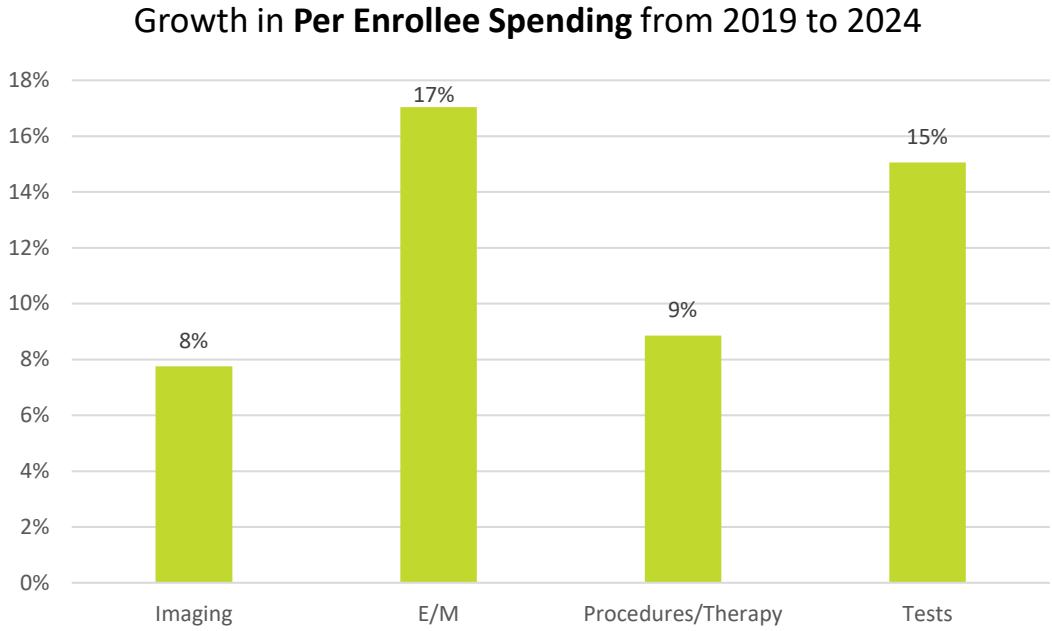
MPFS Spending *Per Enrollee* by Quarter

Cumulative Growth 2019-2025 Q1

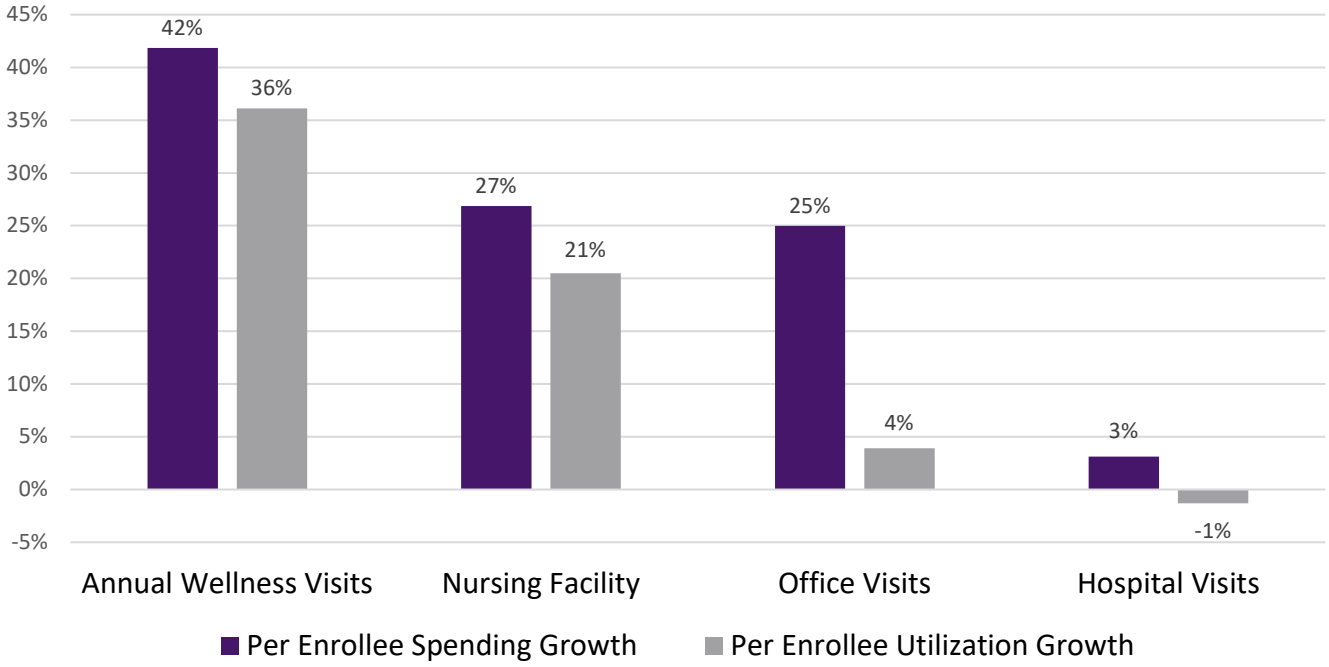


MPFS Spending by Type of Service



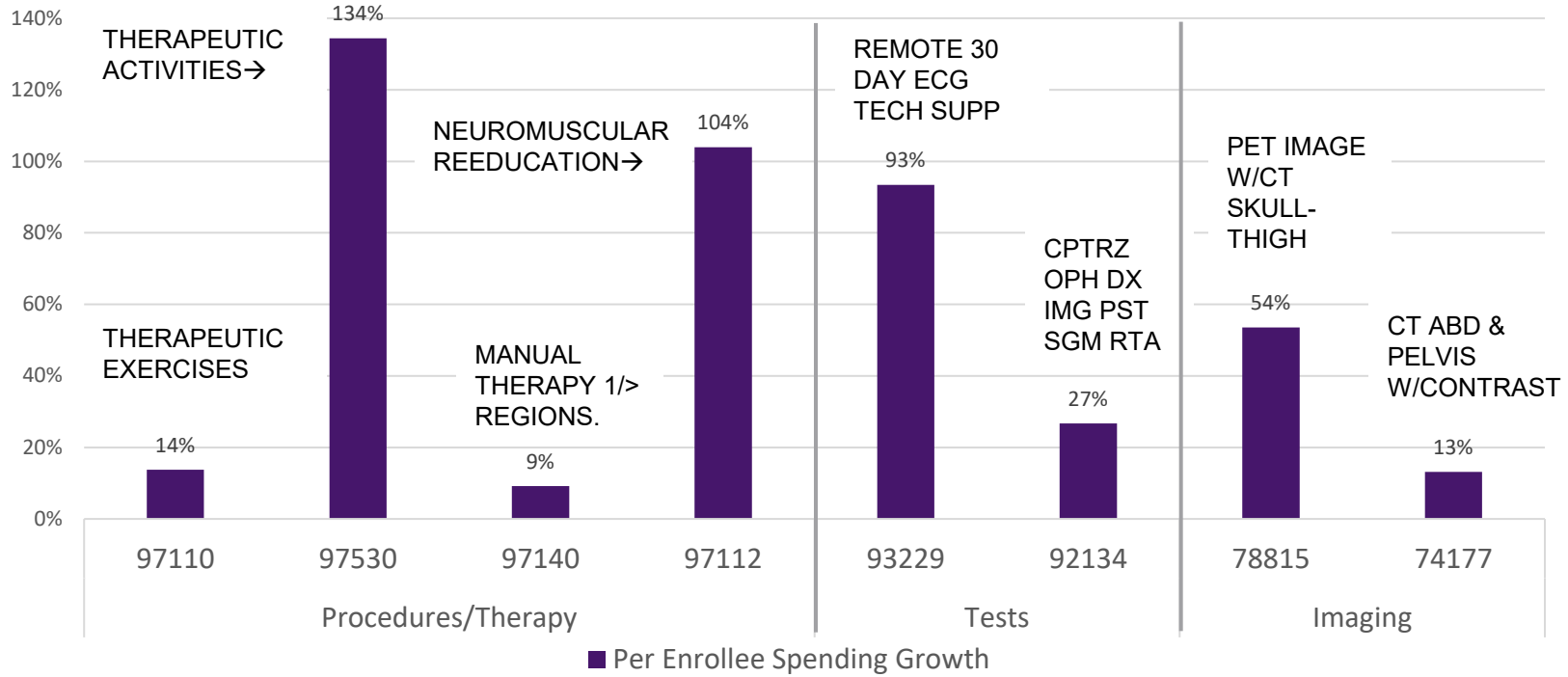


E/M *Per Enrollee* Spending and Utilization Growth (2019-2024)

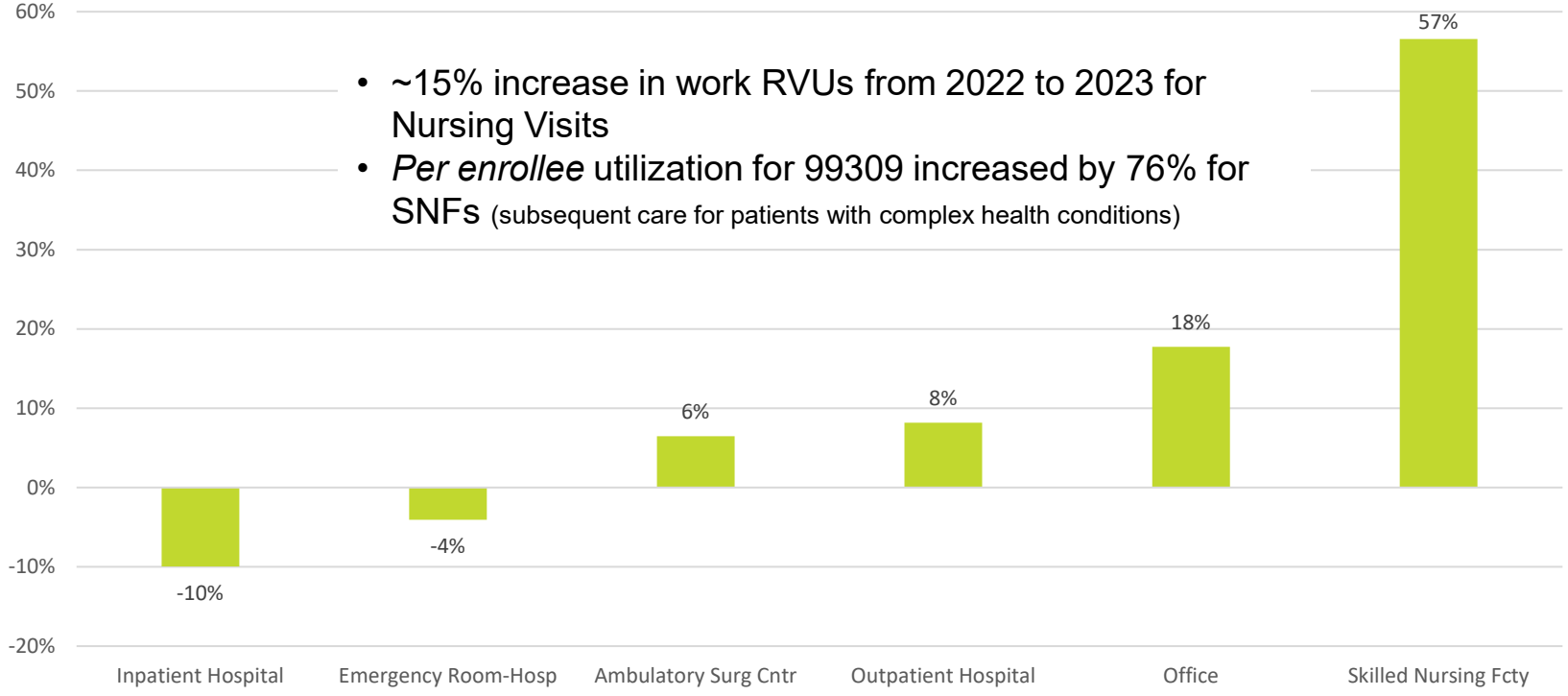


Procedures/Therapy, Tests, Imaging (2019-2024)

Top Codes with above average per enrollee growth

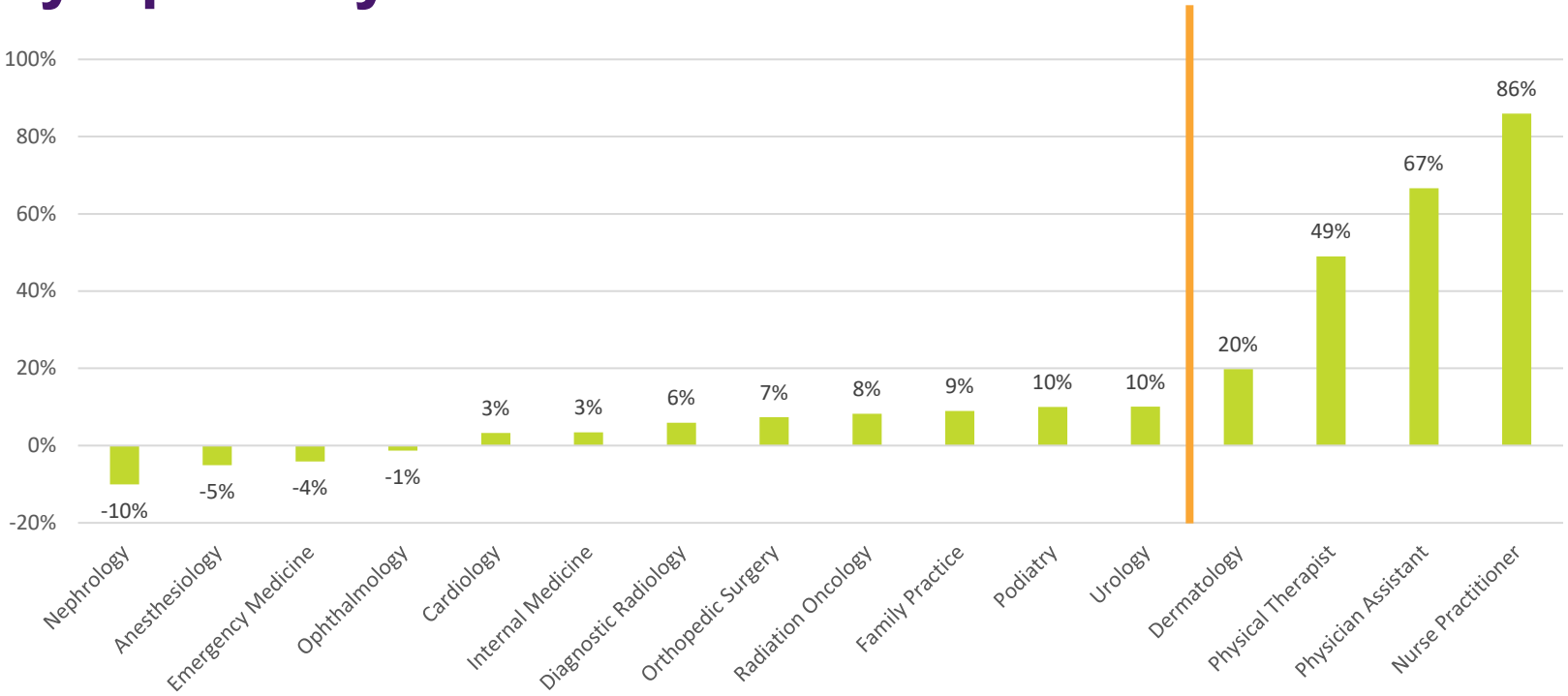


MPFS Spending *Per Enrollee Growth* 2019-2024 by Place of Service



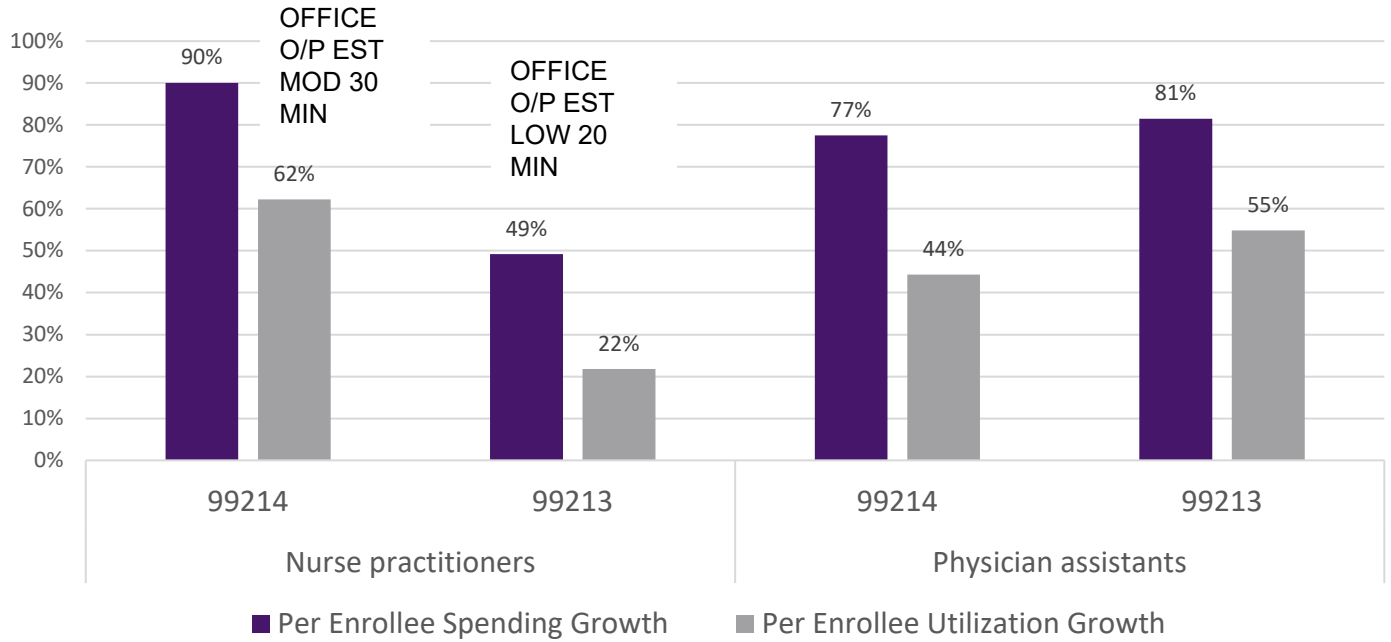
- ~15% increase in work RVUs from 2022 to 2023 for Nursing Visits
- *Per enrollee* utilization for 99309 increased by 76% for SNFs (subsequent care for patients with complex health conditions)

MPFS Spending *Per Enrollee Growth* 2019-2024 by Specialty

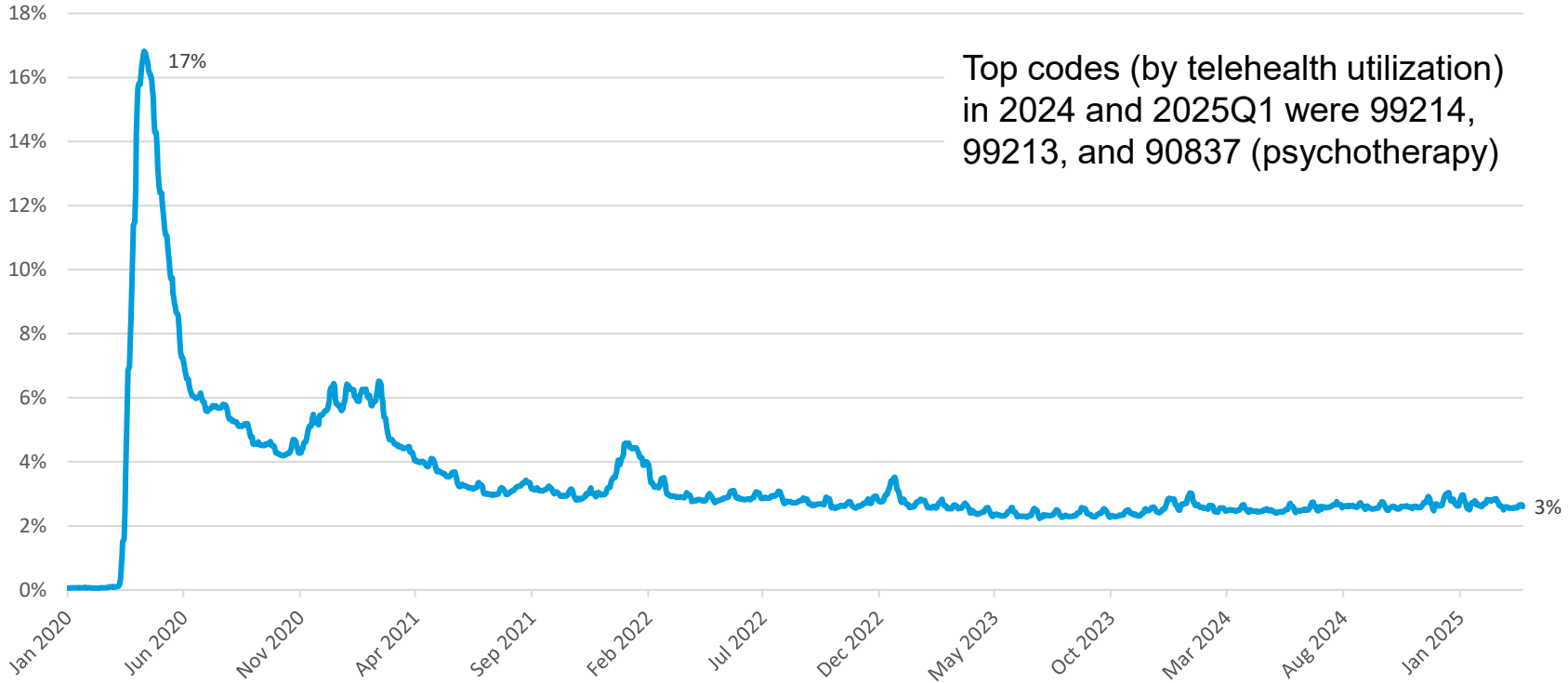


NPs and PAs *Per Enrollee* Spending and Utilization Growth (2019-2024)

Top codes (by utilization)



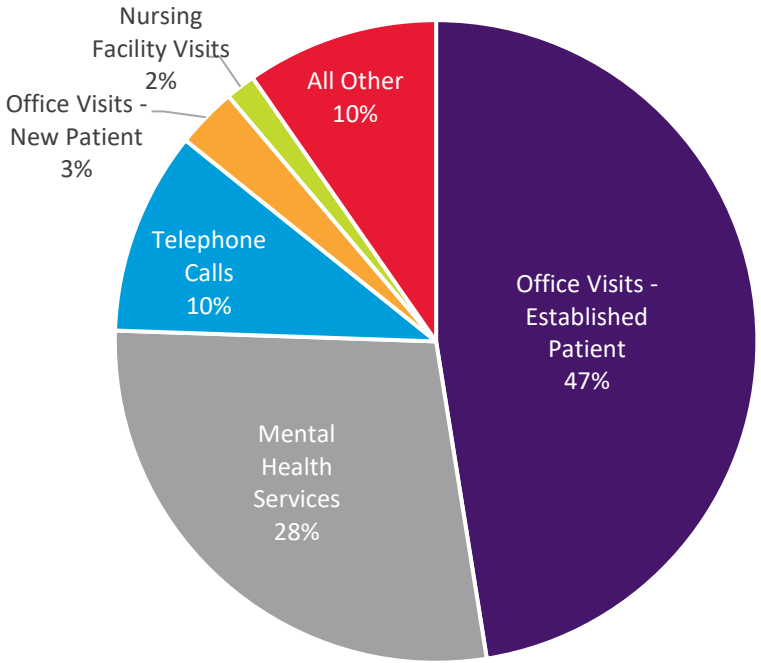
Telehealth Spending as Share of MPFS Total (Jan 2020 – Mar 2025)



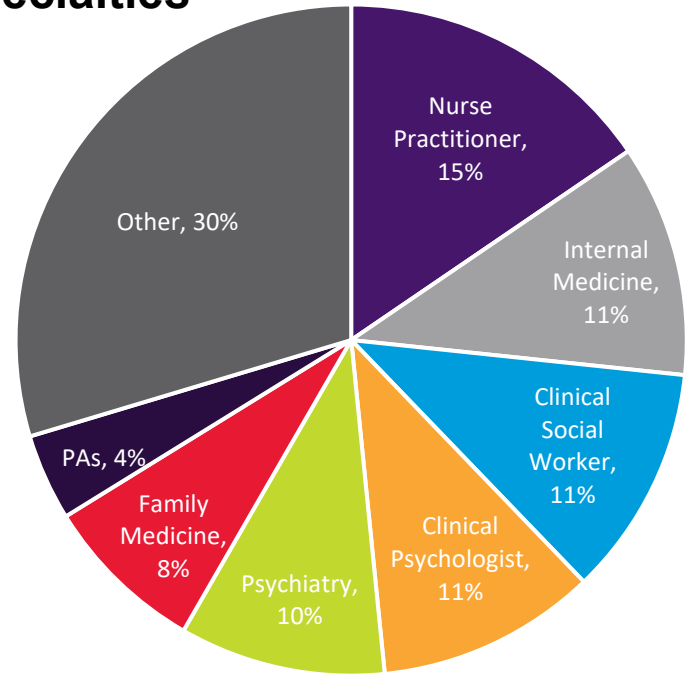
Top codes (by telehealth utilization) in 2024 and 2025Q1 were 99214, 99213, and 90837 (psychotherapy)

Decomposing the ~$2.4B Spent on Telehealth in 2024

Service Categories



Specialties

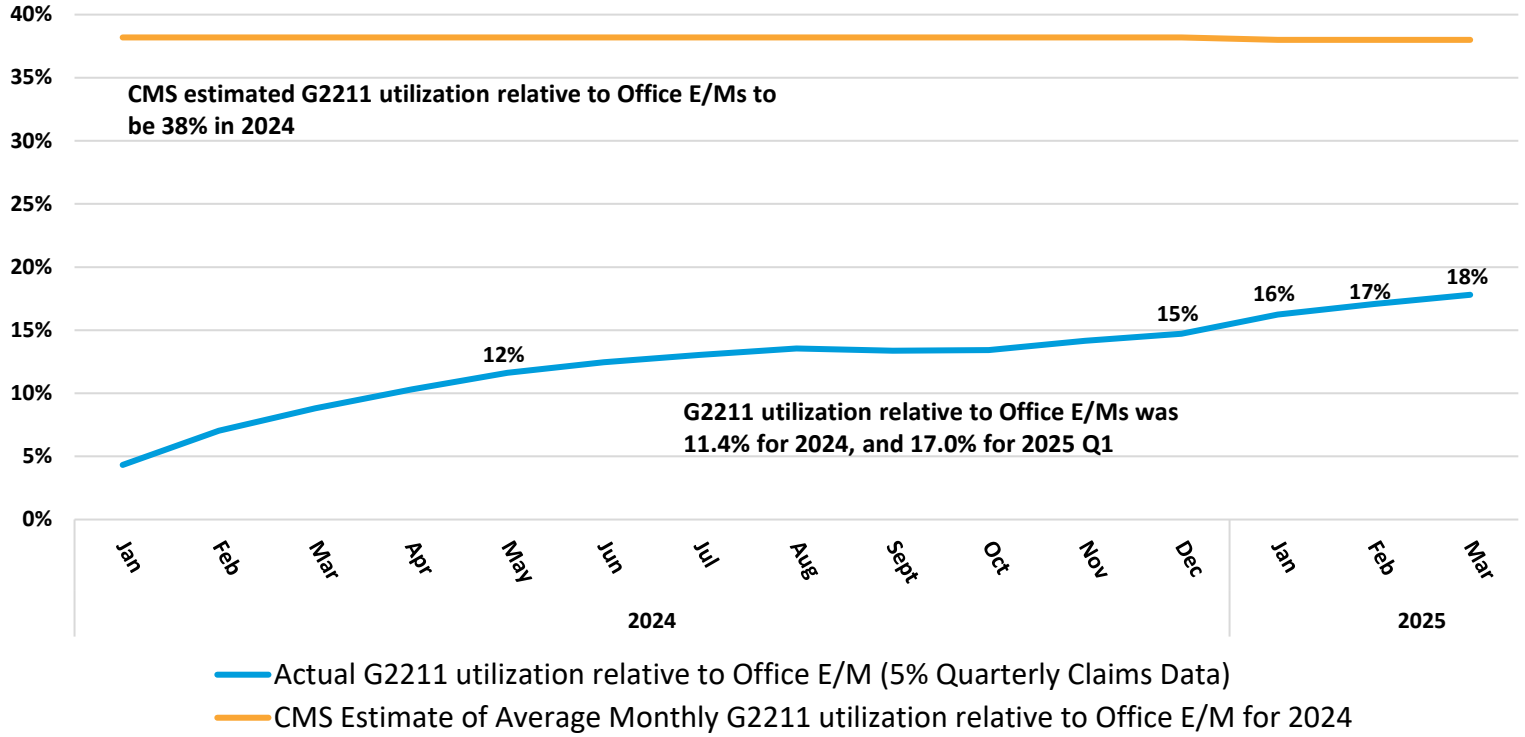


Select New Codes 2024-2025 Q1

G2211 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.
  - Introduced in 2024.
  - 2025: mod 25 allowed if there is also a separate, applicable AWV/Imm Code
- **2024 Final Rule:**
  - “G2211 will be billed with 38 percent of all O/O E/M visits”
  - “G2211 could be billed with 54 percent of all O/O E/M visits when fully adopted.”
  - **“**the specific portion of the total budget neutrality adjustment attributable to the proposal to make payment for the O/O E/M inherent complexity add-on code to be approximately 2.00 percent”
- **2024-2025 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.

G2211 Utilization *Relative to Office E/M* by Month



G2211 Utilization and Spending

	CMS Estimate for 2024	Actual Claims 2024	Actual Claims 2025 Q1
Utilization	83.7M	24.6M	9.3M
Spending	$1.3B	$395M	$141M

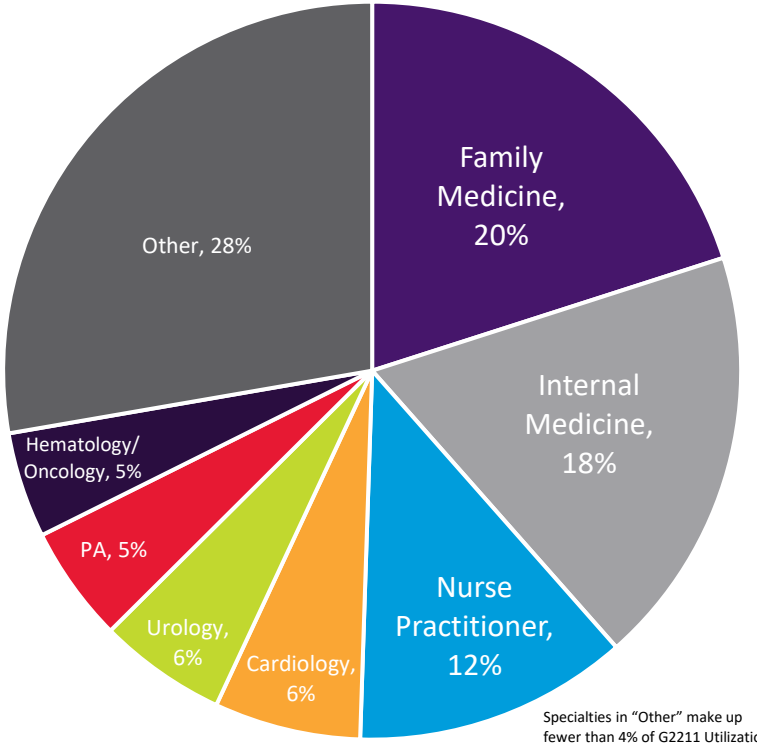
- CMS estimated G2211 utilization to be **3.4x** the actual use in 2024.
- This suggests a nearly $1 billion overestimate in spending in 2024.
- G2211 utilization relative to Office E/M utilization is
  - **11.4% in 2024** compared to the estimated 38% in the final rule.
  - **17.0% in 2025 Q1** compared to the expectation of 54% when fully adopted.

G2211 Conversion Factor Impact

Table 116 Modified (2024 Final Rule): Calculation of CY 2024 CF				
	Updated Conversion Factor			
	1/1/24 to 3/8/24 1.25% Physician Update		3/9/24 to 12/31/24 2.93% Physician Update	
Steps	**Original** BNA (2.18% decline)	**Corrected** BNA	**Original** BNA (2.18% decline)	**Corrected** BNA
CY2023 Conversion Factor	33.89	33.89	33.89	33.89
CF w/o the CAA 2023 (2.5% increase)	33.06	33.06	33.06	33.06
CY2024 RVU Budget Neutrality Adjustment	32.34	32.80	32.34	32.80
CY2024 Physician Update	32.74	33.21	33.29	33.76
CY2024 Conversion Factor	**32.74**	**33.21**	**33.29**	**33.76**
Conversion Factor Cut (from 2023 to 2024)	-3.4%	-2.0%	-1.8%	-0.4%
Note: The corrected budget neutrality adjustment (BNA) adjusts the original BNA based on the fact that 90% of the BNA was due to G2211 and that CMS overestimated utilization and spending of G2211 by 3.4x.				

The 2024 cut to the CF was ~1.5-2.5 larger than it should have been.

G2211 Utilization by Specialty (2024-2025 Q1)



Specialties in "Other" make up fewer than 4% of G2211 Utilization

G2211 Utilization *Relative to Office E/M* by Specialty

G2211 utilization relative to eligible Office E/M utilization is **12.5% from 2024-2025 Q1.** For specialties that utilized G2211 the most:

- Family practice: 22%
  - For every 100 Office E/M services provided by a family practice physician, 22 of those services had G2211 added on.
- Internal medicine: 20%
- Nurse practitioner: 11%
- Urology: 25%
- Cardiology: 15%
- Physician assistant: 8%

G0556, G0557, G0558
Advanced Primary Care Management

- APCM services provide patients with a wide range of services to meet their individual needs based on complexity and are billed using a monthly bundle (not time-based).
- New to 2025, CMS estimated 1.8M utilization for 2025.
- 2025 Q1 Claims Data show:
  - ~260K utilization and ~$14M in allowed charges.
  - Utilization was 44% less than expected (compared to average per quarter)
  - Utilization by specialty: Nurse Practitioner (34%), Family Medicine (29%), Internal Medicine (23%), Emergency Medicine (9%)

G0545

- G0545 is the add-on code for billing specialized infectious disease E/M services during hospital inpatient or observation care (99221–99233).
- New to 2025, CMS estimated 9K utilization for 2025.
- 2025 Q1 Claims Data show:
  - ~325K utilization and $14M in allowed charges.
  - Utilization was almost 150x larger than expected (compared to average per quarter)
  - Utilization by specialty: 81% Infectious Disease (ID) and 11% Internal Medicine.
  - ID specialty billed G0545 with eligible hospital/observation E/M codes 26% of the time (i.e., for every 100 hospital/observation E/M visits, 26 of them had this add-on).

Modifier 54

- Mod 54: used to indicate only the surgical portion of the procedure was performed by the physician and there was a transfer of care during the global surgery period (for surgical care only).
  - New to 2025: Informal transfers of care are now required to use mod 54.
- Q1 claims data
  - Only 2% different from the CMS estimate for 2025 (average per quarter)
  - Limited changes in 2025.
  - Ophthalmology are 85% of allowed charges in 2025 Q1 (87% in 2024 Q1).
  - Emergency medicine are 11% of allowed charges in 2025 Q1 (10% in 2024 Q1)
    - 14% per enrollee spending growth from 2024 Q1 to 2025 Q1.

Per enrollee growth from previous year Q1		
	Spending	Utilization
2023	-1.2%	-0.2%
2024	-2.3%	0.3%
2025	-1.5%	1.2%

75580, 92229
Artificial Intelligence

- 75580 is noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography.
  - New to 2024, CMS estimated utilization to be 9K.
  - 2024 Quarterly Claims Data: 27K utilization and $9M in spending.
    - 47% of utilization was from Cardiology
- 92229 is imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral.
  - New in 2021, CMS estimated utilization to be 1K in 2024.
  - 2024 Quarterly Claims Data: 5K utilization and $211K in spending.
    - From 2021 to 2024, per enrollee spending increased by 12x

Wrap-up

Quarterly Claims Data show:

MPFS

- **Per enrollee spending increased by 15% (2019-2025 Q1)**
- **E/M saw more growth compared to other type of service categories (2019-2024)**
- **SNF and Offices saw more growth compared to other place of services (2019-2024)**
- **NPs and PAs saw more growth compared to other specialties (2019-2024)**

G2211 (2024-2025 Q1): Utilization of this code is significantly less than expected, but still growing.

Questions?

AMA/Specialty Society RVS Update Committee **Tab 26**
Research Subcommittee Meeting Report
September 25, 2025

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

I. Review of the May 19th Research Subcommittee Conference Call Reports

The Research Subcommittee reports from the May 19th conference call included in Tab 26 agenda materials were approved without modification.

II. Use of Electronic Health Record Data to Validate Time Data

Nate Apathy, PhD, Assistant Professor of Health Policy & Management at the University of Maryland School of Public Health, provided a presentation on the use of EHR audit log data to estimate service/procedure time. Dr. Apathy went into detail on what EHR audit log data captures and makes it distinct from other data sources. He provided an example of audit log data which aligns with a time motion study of an individual office visit. He also gave suggestions for potential pilot studies that could be relevant to the RUC process.

What is EHR audit log data?
Dr. Apathy explained that EHR audit log data is a record of activity inside the EHR; it is linked to EHR user, the patient, and has time-stamp data. It includes general data on who accessed which patient record at what time and actions were taken (e.g., view, modify, delete). Audit log data has several key limitations, including that it does not capture the universe of clinical activities as there many types of clinical activity that occur outside of the EHR. It is limited in scope to what in that it will not include information from other non-integrated technology used in care. Different developers and different organizations capture different levels of detail in audit log data.

What can EHR audit log data uniquely capture?
Dr. Apathy noted that major clinical events and their timestamps do not require the audit log and can be captured from other datasets (ie placing an order, completion of an imaging or lab test, completion of clinical documentation, completion of patient registration, etc.). What audit log data is uniquely suited for are the interstitial events that go into those major events, including opening/closing a patient's chart, incremental edits to documentation, initiating a registration workflow and the sequencing of a user's workflow. Dr. Apathy noted that, for the sample AMA RUC use case, these interstitial events are more likely to be demarcations of pre/intra/post-service time, and they capture micro-activity across the entire clinical team relatively easily.

Dr. Apathy showed the audit log data from an example office visit that is paired with a recording of the visit that is publicly available: https://observer.med.upenn.edu/dataset/explore. For this example case, the audit log data underrepresented the actual physician time by 8%.

Benefits of audit log-derived measures
Dr. Apathy explained that audit log data is systematically collected for all visits and can be organized by visit, patient, and/or user. He noted that audit log data definitionally captures all activity in a given patient's chart and this would be its core use case for researchers. Researchers can also leverage start-

points and end-points of "clusters" of activity to estimate time, which can be augmented by the Researchers developing and applying rules for interpreting the audit log data. It is also possible to observe the initiation of specific workflows (e.g., registration). He noted that face-to-face time with the patient can be inferred and accounted for, as long as it is surrounded by some EHR use.

Drawbacks of audit log-derived measures
Dr. Apathy noted that it is challenging to account for workflow, staffing, and teamwork differences across physicians and organizations, though it is possible to partially mitigate this challenge by relying on the law of large numbers. For example, researchers could extract audit logs for observed procedures and larger (but not directly observed) samples of the same procedure. Dr. Apathy also noted it is difficult (if not impossible) to capture cognitive intensity of work; this is a major potential issue for primary care specialties in particular. He also noted that audit log data can underestimate active time for activities that predominantly involve non-logged behavior (e.g., reading & writing notes). It was also observed that each CPT code will likely have slightly different ways to define start/stop times in the audit log, but it is possible to observe these and design them in.

Potential Pilot Studies
Dr. Apathy suggested two potential pilot studies that may be useful to the RUC process. One involved selecting a specific RUC clinical staff or physician time standard, such as the physician post-service time standard for the operative note or clinical staff standard for vital signs. This would involve identifying the specific logged events that correspond with this activity for a sample of surgical procedures and determining the start and stop time of these specific activities in the log. The second pilot study concept involves selecting a small sample (5-10) of CPT codes, conducting direct observation of a small sample of these services in person and extracting the audit log data for these procedures. Next would involve matching the observation data to the audit logs for the observed sample to construct rules for start and end points. These rules could be applied to a larger non-observed audit log dataset at scale and used to compare to survey data.

Q&A
Dr. Apathy fielded several questions from Research Subcommittee members and other RUC members. He fielded several questions about the variability of workflows among physicians. Dr. Apathy concurred that this is a limitation in the audit log data and that is the reason for supplementing it with direct observation to design code-specific rules and relying on large sample sizes of audit log data. He also fielded a question about using eye tracking and click data; he noted that these data are useful but extraordinarily expensive to use even at small scale limiting their utility for analyzing clinical workflows. A Subcommittee member noted that pairing audit log data with claims data relies on the assumption that the services were correctly coded. Another asked about when the clock starts and provided an example of reviewing imaging before a procedure in a separate system outside of the EHR. Dr. Apathy agreed that this is another limitation where EHR audit log data will not include information from other non-integrated technology used in care. A member offered the idea of using ambient AI time stamps to supplement audit log data; Dr. Apathy concurred that looking at these data in parallel would be useful. A RUC member asked if the operating room or clinical schedule can be used to inform Researchers when using audit log data; Dr. Apathy confirmed that using other datasets would have utility in informing studies.

Doctor Weida, the Chair of the Research Subcommittee, thanked Dr. Apathy for the informative presentation and noted that the Research Subcommittee would further discuss potential pilot studies.

III. Maternity Care Services: Custom Survey Instruments and Vignette Request

American College of Obstetricians and Gynecologists
American Nurses Association

At the September 2025 CPT Editorial Panel meeting, the Panel approved significant changes to the Maternity Care Services (MCS) CPT codes. The societies submitted a request to the Research Subcommittee to review the following 5 proposed custom survey templates and vignette changes. All surveys would include the full CPT language as a reference for the survey respondents.

The Research Subcommittee approved the following customizations to the Maternity Care Services survey templates:

- **Labor Management Survey (59XX1-59XX4):** The societies proposed to use the February 2022 inpatient and observation care services survey instrument to survey the new labor management codes and collect total time on day of encounter, with some additional modifications. The Subcommittee discussed the proposed changes and concurred they were appropriate. The Subcommittee concurred that the changes would be clear that these services are for all physicians/QHPs in the same group practice. Specifically, the changes involved removing inpatient specific language, including the full CPT guidelines for the new labor management codes and then also modify the following:

    - ***Update the "time on date of encounter" definition.***

    ~~When total~~ t Time on the date of encounter is ~~used to select the appropriate level of an inpatient and observation care service code,~~ defined as both the face-to-face and non-face-to face time personally spent by the physician or QHP and other physicians or QHPs in the same group and same subspecialty that ~~is~~ are reporting ~~the~~ a single ~~inpatient/observation care visit assessing and managing the patient are summed to select the appropriate~~ labor management code. Please consider all the time spent on the service for a full calendar day.

    - ***Edit the following total time tally question:***

    Please confirm that the above Total Time estimates, which aggregated your responses to the previous survey question, represent the total physician/QHP time on the date of encounter that is required per patient treated ~~for each of the following steps in patient care~~ related to the survey code(s). If you wish to adjust any of your time estimates after reviewing the Total Time, click the BACK button below, and update your estimates as needed.

    - ***Delete the custom multiple physician/QHP question.***

    ~~On a single calendar day, will there typically (ie, more than 50% of the time) be more than one physician/QHP who spends time providing CPT code 99XXX for the typical patient described above.~~

- **Delivery Survey (59XX5, 59XX6, 59414, 59300, 59X11, 59X12, 59XX7 and 59XX8):** The surveying societies plan to use the standard 000 survey template with a few modifications. A link to

the new Maternity Care Services Guidelines will be included.

- Include a custom question when both the American College of Nurse-Midwives (ACNM) and 59X12 are marked off:

  "Please confirm you are privileged at your hospital to perform *Repair of episiotomy or laceration; fourth-degree laceration. (Midwife expanded scope of practice)"*
  If no – will not display 59X12

- The Research Subcommittee modified a request to include questions about which provider typically performs 59X11 and 59X12. The data from these questions will help ensure appropriate accounting for pre/post times.

  59X11 *Repair of episiotomy or laceration; third-degree laceration*

  When you perform a delivery and there is a third-degree laceration, who typically performs the repair?
  a. I typically perform the third-degree laceration repair
  b. Another physician or other QHP typically performs the third-degree laceration repair

  59X12 *Repair of episiotomy or laceration; fourth-degree laceration*

  When you perform a delivery and there is a fourth-degree laceration, who typically performs the repair?
  a. I typically perform the fourth-degree laceration repair
  b. Another physician or other QHP typically performs the fourth-degree laceration repair

- Include the following question: Do you take the parturient to the operating room to perform the repair? Yes or No

- Edit Question #2c (Place of Service)
  a. Typically performed at a hospital/birthing center for services performed in a birthing center (59XX5, 59XX6, 59414, 59300, 59X11 and 59X12).
  b. Typically performed in the home setting as a 4th option for CPT Code 59XX5 *Vaginal delivery, with or without episiotomy.*

- Remove pre-service evaluation time questions (day proceeding and day of) for 59XX5 and 59XX6. CPT defines "*Delivery care begins when labor is complete (presenting part of the fetus is visible and firmly rimmed by the vaginal introitus) or interrupted (eg, arrest of labor is diagnosed and subsequent decision for cesarean delivery is made).* Pre-service evaluation time is included in the labor management codes for vaginal births (59XX5 and 59XX6).

- **Cesarean Hysterectomy (C-Hyst) Survey (59XX9):** The surveying societies plan to use the standard 000 survey template with a few modifications.
  - Include the following language in the C-Hyst Guidelines section:

  Please complete this survey as the surgeon called in to perform the subtotal or total hysterectomy during the same operative session as the cesarean delivery.

- Edit Question #2
    - Remove day preceding procedure pre service evaluation time question.
    - Edit the "Note" sentence as follows:

    ~~Note:~~ IMPORTANT: Do not include time for work related to another service, procedure, or evaluation and management code that is separately reportable. Only include your own time, as the surgeon, who performed the subtotal or total hysterectomy after cesarean delivery. This should not include time of the primary surgeon, who performed the cesarean delivery.

During the discussion, the vignette was discussed as well and the Research Subcommittee and the societies agreed to a modification.

The Research Subcommittee agreed to the following modified vignette for 59XX9:

59XX9 Subtotal or total hysterectomy after cesarean delivery

Research-Approved Vignette: A 34-year-old female, gravida 3, para 3 with known placenta accreta spectrum (PAS) has intractable bleeding during her cesarean delivery and requires a hysterectomy.

- **Antepartum/Postpartum Survey (59320, 59325, 59412, 59871, 59X10 and 59160):** The surveying societies plan to use the standard 000 survey with the following modification.
    - Edit Question #2c (Place of Service)
        - Typically performed at a hospital/birthing center for services performed in a birthing center (59412 and 59X10).

Separately, the societies also submitted a proposed vignette for CPT code 59030, which currently does not have a vignette in the RUC database. **The Research Subcommittee approved the vignette as submitted:**

CPT Code 59030 Fetal scalp blood sampling:
Research-Approved Vignette: A 33-year-old female, gravida 1, para 0 at 38 weeks gestation, is in the active phase of labor. The fetus has persistent minimal variability requiring fetal scalp blood sampling.

Using EHR Audit Log Data for Service Time Estimation

AMA RUC Research Subcommittee | September 25, 2025

SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF MARYLAND
INSTITUTE FOR HEALTH COMPUTING
MPOWERING THE STATE

Nate C. Apathy, PhD
Assistant Professor, Health Policy & Management
University of Maryland School of Public Health
University of Maryland Institute for Health Computing

This deck: https://go.umd.edu/ama_ruc_92525

Outline

What is EHR Audit Log Data?

What does the audit log capture that other data sources do not?

An Example

Potential Pilot Studies

Time standards & service time estimates

Discussion

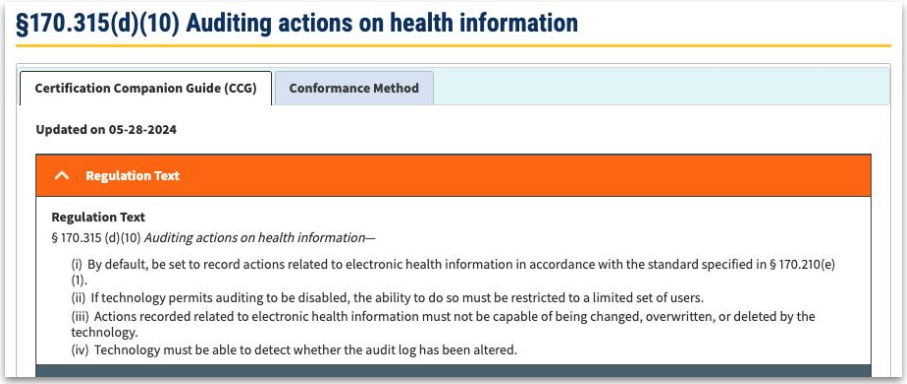
https://go.umd.edu/ama_ruc_92525

What is EHR audit log data?

Key Features

- A record (“log”) of what a user did inside the EHR
- Track user activity while logged into the EHR
- Originally designed to track access to charts
  - ***Auditing*** if anyone improperly accessed
- Who accessed which patient record at what time & actions taken (e.g., view, modify, delete)
- Can measure EHR-based clinical activity at scale
  - Historically done w/ time & motion studies

ASTP Assistant Secretary for Technology Policy



§170.315(d)(10) Auditing actions on health information

Certification Companion Guide (CCG) | Conformance Method

Updated on 05-28-2024

Regulation Text

Regulation Text

§ 170.315 (d)(10) *Auditing actions on health information*—

(i) By default, be set to record actions related to electronic health information in accordance with the standard specified in § 170.210(e)(1).

(ii) If technology permits auditing to be disabled, the ability to do so must be restricted to a limited set of users.

(iii) Actions recorded related to electronic health information must not be capable of being changed, overwritten, or deleted by the technology.

(iv) Technology must be able to detect whether the audit log has been altered.

https://go.umd.edu/ama_ruc_92525

What is EHR audit log data?

Key Features

- A record (“log”) of what a user did inside the EHR
- Track user activity while logged into the EHR
- Originally designed to track access to charts
  - ***Auditing*** if anyone improperly accessed
- Who accessed which patient record at what time & actions taken (e.g., view, modify, delete)
- Can measure EHR-based clinical activity at scale
  - Historically done w/ time & motion studies

Limitations

Not purpose-built for research or post-hoc analysis

Does not capture the universe of clinical activity
- Lots of clinical activity occurs outside the EHR

Not eye-tracking; don’t know what exactly the user is looking at

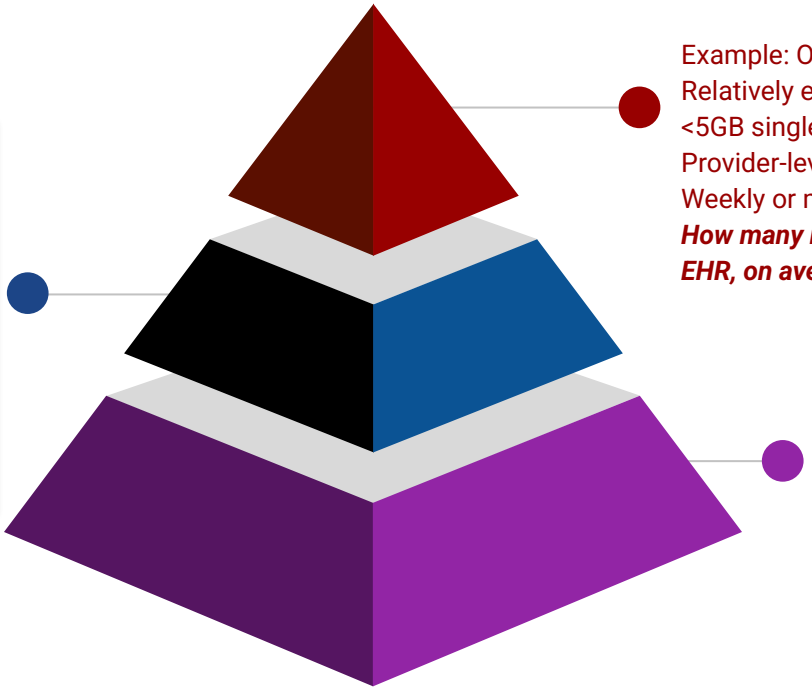
Limited in scope to the EHR system and anything integrated (e.g., bedside devices)
- Won’t include information from other non-integrated technology used in care

Different **developers** capture different levels of detail in their audit logs (above the minimum requirements)

Different **organizations** configure more or less detailed auditing (above the minimum requirements)

Layers of log data you may be familiar with

Audit Log Data
regulatory requirement
Ex: Oracle Sentinel; Epic Access Log
Fairly difficult to use
Need to know what you're looking for
Very large datasets, highly variable
Click-level(ish) activity
Can be merged with clinical data
No aggregation
Did Dr. Smith use the Dashboard?



Active Use Metadata (aka "stopwatch data")

Example: Oracle Health Advance; Epic Signal
Relatively easy to use
<5GB single site for 1 year of data
Provider-level measures (no clinical linkage)
Weekly or monthly aggregation
How many minutes per visit did Dr. Smith spend in the EHR, on average, in October 2021?

Micro-Activity Log Data

Example: Epic User Activity Log (UAL)
Very difficult to use
Extremely large data (>100GB single site)
Keystrokes, cursor coordinates
Can be linked to clinical data (very hard)
No aggregation
How many mouse miles and clicks did it take for Dr. Smith to place an order?

Examples of studies using different layers of log data

National Comparison of Ambulatory Physician Electronic Health Record Use Across Specialties

A Jay Holmgren [1], Christine A Sinsky [2], Lisa Rotenstein [3], Nate C Apathy [4]

AMA

Epic SIGNAL

JAMA Internal Medicine | Original Investigation | PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Physician EHR Time and Visit Volume Following Adoption of Team-Based Documentation Support

Nate C. Apathy, PhD; A. Jay Holmgren, PhD, MHI; Dori A. Cross, PhD

Epic SIGNAL

The Impact of Team-Based Ordering Workflows on Ambulatory Physician EHR Time, Order Volume, and Visit Volume

Nate C. Apathy[1,2] | Alice S. Yan[1] | A. Jay Holmgren[3]

Epic SIGNAL

AMA

Original Investigation | Health Policy

Anesthesia Clinical Workload Estimated From Electronic Health Record Documentation vs Billed Relative Value Units

Sunny S. Lou, MD, PhD; Laura R. Baratta, BS; Daphne Lew, PhD, MPH; Derek Harford, BA; Michael S. Avidan, MBBCh; Thomas Kannampallil, PhD

What does the audit log actually look like?

id	visit_id	access_time	user_id	workstation_id	access_action	metric_id	metric_name	metric_desc	metric_group	event_action_type
105	103	3/15/2025 10:20:20	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20607	Storyboard viewed	AC_STORYLINE_VIEWED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
106	103	3/15/2025 10:20:20	GgiTE2kR7vxV	gYuaVsfxmenFVmE	QUERY	72026	Care Everywhere outside data auto-requested	CE_CHART_OVERVIEW_AUTO_RQST	EVENT AREA - PATIENT CLINICAL INFO	VIEW
107	103	3/15/2025 10:20:21	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20620	Visit Navigator template loaded	AC_VISIT_NAVIGATOR	EVENT AREA - PATIENT CLINICAL INFO	VIEW
108	103	3/15/2025 10:20:22	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20620	Visit Navigator template loaded	AC_VISIT_NAVIGATOR	EVENT AREA - PATIENT CLINICAL INFO	VIEW
109	103	3/15/2025 10:20:22	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17338	OurPractice Advisories displayed	MR_BPA_DISPLAYED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
110	103	3/15/2025 10:20:22	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17126	Allergies activity accessed	MR_ALLERGIES	EVENT AREA - PROBLEMS	VIEW
111	103	3/15/2025 10:20:24	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
112	103	3/15/2025 10:20:27	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
113	103	3/15/2025 10:20:27	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
114	103	3/15/2025 10:20:27	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
115	103	3/15/2025 10:20:27	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
116	103	3/15/2025 10:20:27	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	20030	SmartLink used	AC_SMARTLINK_ACCESS	EVENT AREA - WORKFLOW	VIEW
117	103	3/15/2025 10:20:40	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17259	Patient SnapShot viewed	MR_SNAPSHOT_VIEWED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
118	103	3/15/2025 10:21:22	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17158	Visit diagnoses viewed	VISIT_DIAGNOSES_VIEW	EVENT AREA - PROBLEMS	VIEW
119	103	3/15/2025 10:21:29	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	60010	Pend clinical note	UCNNOTE_PEND	EVENT AREA - CLINICAL NOTES	MODIFY
120	103	3/15/2025 10:22:59	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	60010	Pend clinical note	UCNNOTE_PEND	EVENT AREA - CLINICAL NOTES	MODIFY
121	103	3/15/2025 10:24:30	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17250	Problem List accessed	MR_PROBLEM_LIST_ACCESS	EVENT AREA - PROBLEMS	VIEW
122	103	3/15/2025 10:24:41	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	49003	Visit diagnoses modified	VISIT_DIAGNOSES	EVENT AREA - PROBLEMS	MODIFY
123	103	3/15/2025 10:24:42	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17338	OurPractice Advisories displayed	MR_BPA_DISPLAYED	EVENT AREA - PATIENT CLINICAL INFO	VIEW
124	103	3/15/2025 10:26:45	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
125	103	3/15/2025 10:26:59	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
126	103	3/15/2025 10:27:14	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	60010	Pend clinical note	UCNNOTE_PEND	EVENT AREA - CLINICAL NOTES	MODIFY
127	103	3/15/2025 10:27:15	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17108	Order list changed	MR_ENC_ORDERS	EVENT AREA - ORDERS	MODIFY
128	103	3/15/2025 10:27:16	GgiTE2kR7vxV	R24QF9ECHMG47	QUERY	17008	Report with patient data viewed	MR_REPORTS	EVENT AREA - PATIENT CLINICAL INFO	VIEW
129	103	3/15/2025 10:32:57	LCRKrysbBBv	gYuaVsfxmenFVmE	QUERY	14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT
130	103	3/15/2025 11:14:42	LCRKrysbBBv	gYuaVsfxmenFVmE	QUERY	14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT
131	103	3/15/2025 11:20:41	LCRKrysbBBv	gYuaVsfxmenFVmE	QUERY	14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT
132	103	3/15/2025 11:32:57	LCRKrysbBBv	gYuaVsfxmenFVmE	QUERY	14200	Printing occurred	E_PRINT	EVENT AREA - WORKFLOW	EXPORT

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

What can we do with audit log data?

Rule A, Chiang MF, Hribar MR. Using electronic health record audit logs to study clinical activity: a systematic review of aims, measures, and methods. *JAMIA*. 2019.

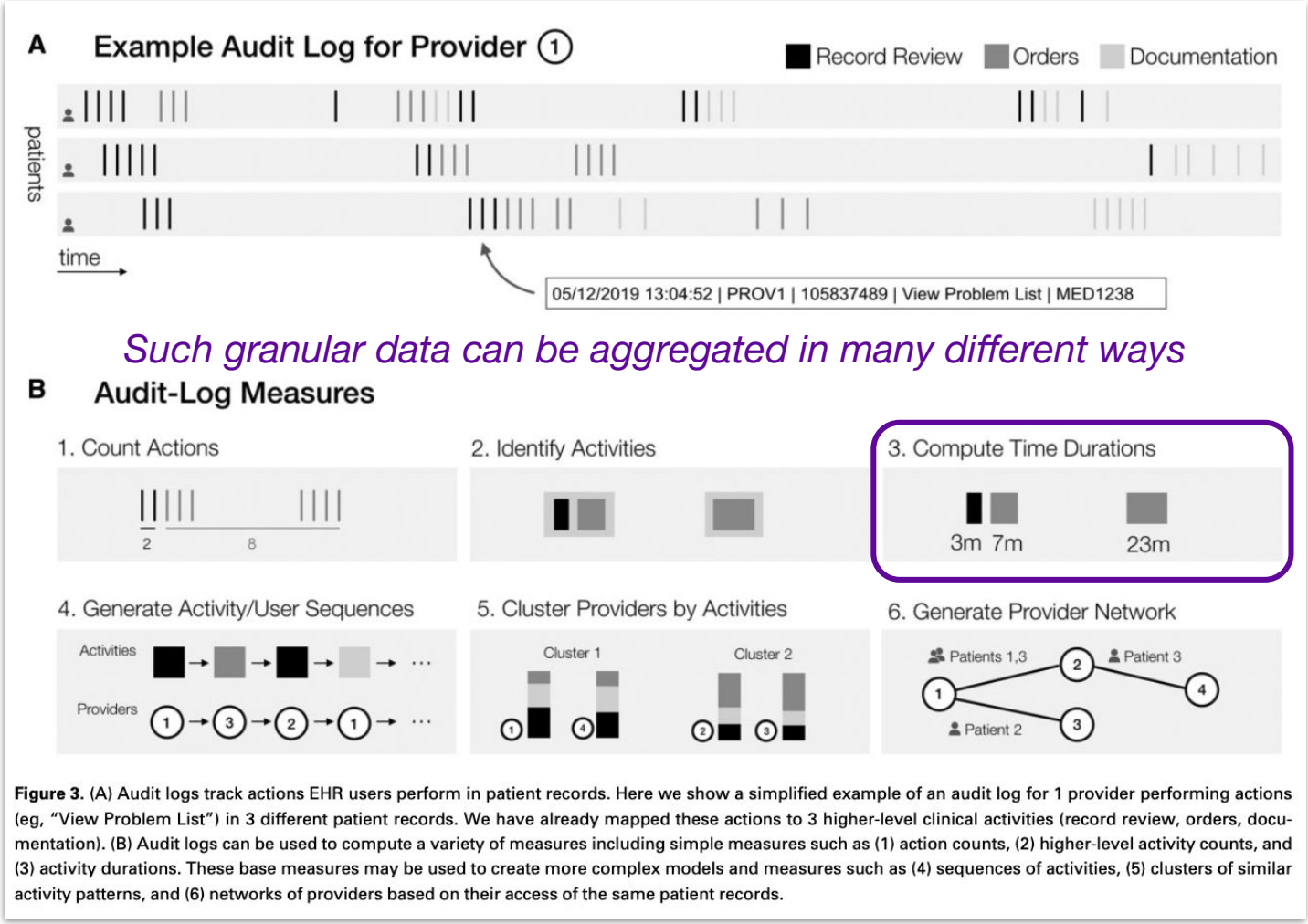


Figure 3. (A) Audit logs track actions EHR users perform in patient records. Here we show a simplified example of an audit log for 1 provider performing actions (eg, "View Problem List") in 3 different patient records. We have already mapped these actions to 3 higher-level clinical activities (record review, orders, documentation). (B) Audit logs can be used to compute a variety of measures including simple measures such as (1) action counts, (2) higher-level activity counts, and (3) activity durations. These base measures may be used to create more complex models and measures such as (4) sequences of activities, (5) clusters of similar activity patterns, and (6) networks of providers based on their access of the same patient records.

What can this data source uniquely capture?

Major clinical “events” and their timestamps **do not require the audit log**

- Placing an order; completion of an imaging or lab test; completion of clinical documentation; completion of patient registration; etc.

The interstitial events that go into those major events **do require the audit log**

- Opening/closing a patient’s chart; incremental edits to documentation; initiating a registration workflow; the *sequencing* of a user’s workflow

For the AMA RUC use case, these interstitial events are more likely to be demarcations of pre/intra/post-service time, and they capture micro-activity across the entire clinical team relatively easily

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Example

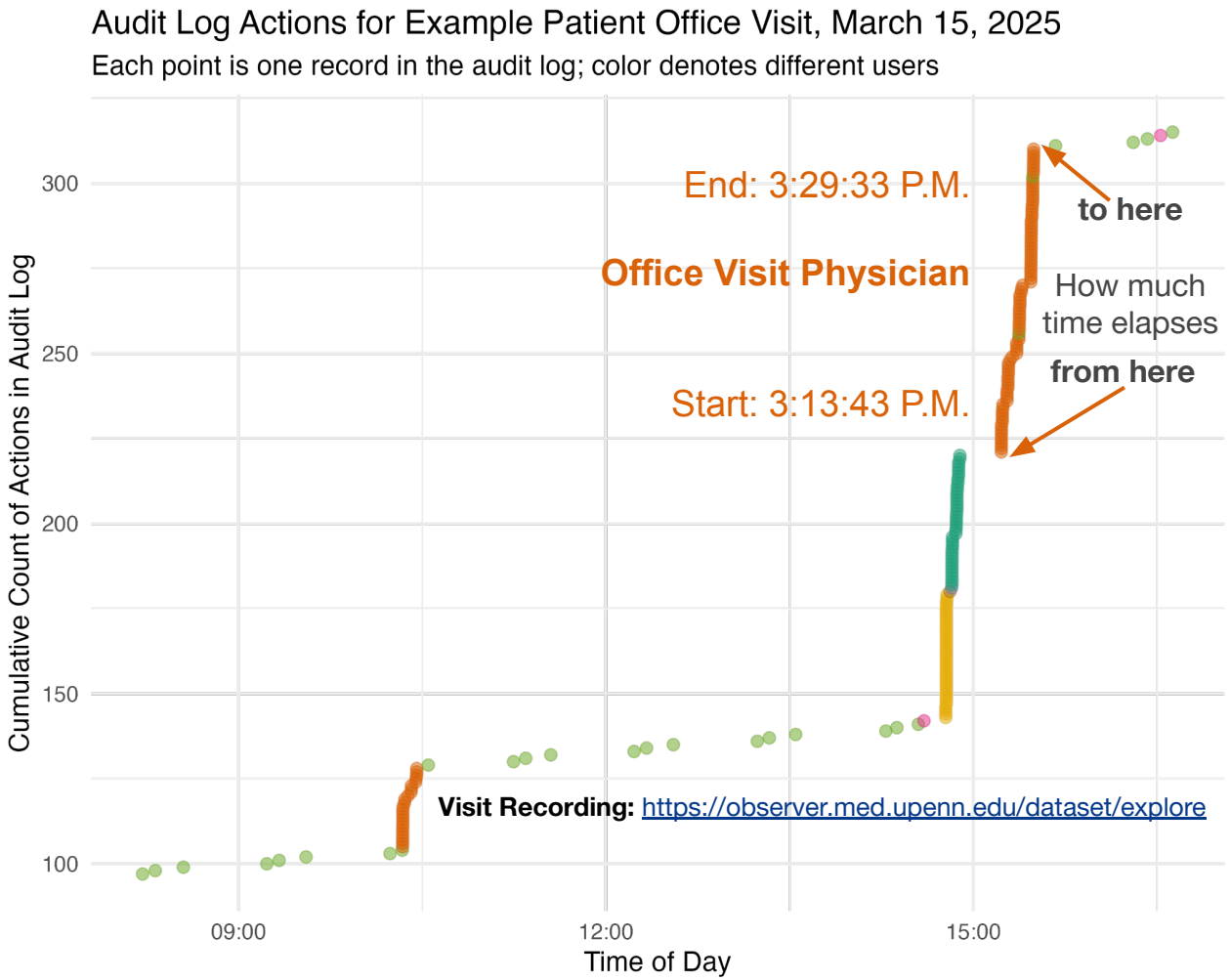
Face-to-face time estimate from audit log activity:

15min 50s

Face-to-face time from visit recording:

17min 14s

84s or ~8.1% less time



Example

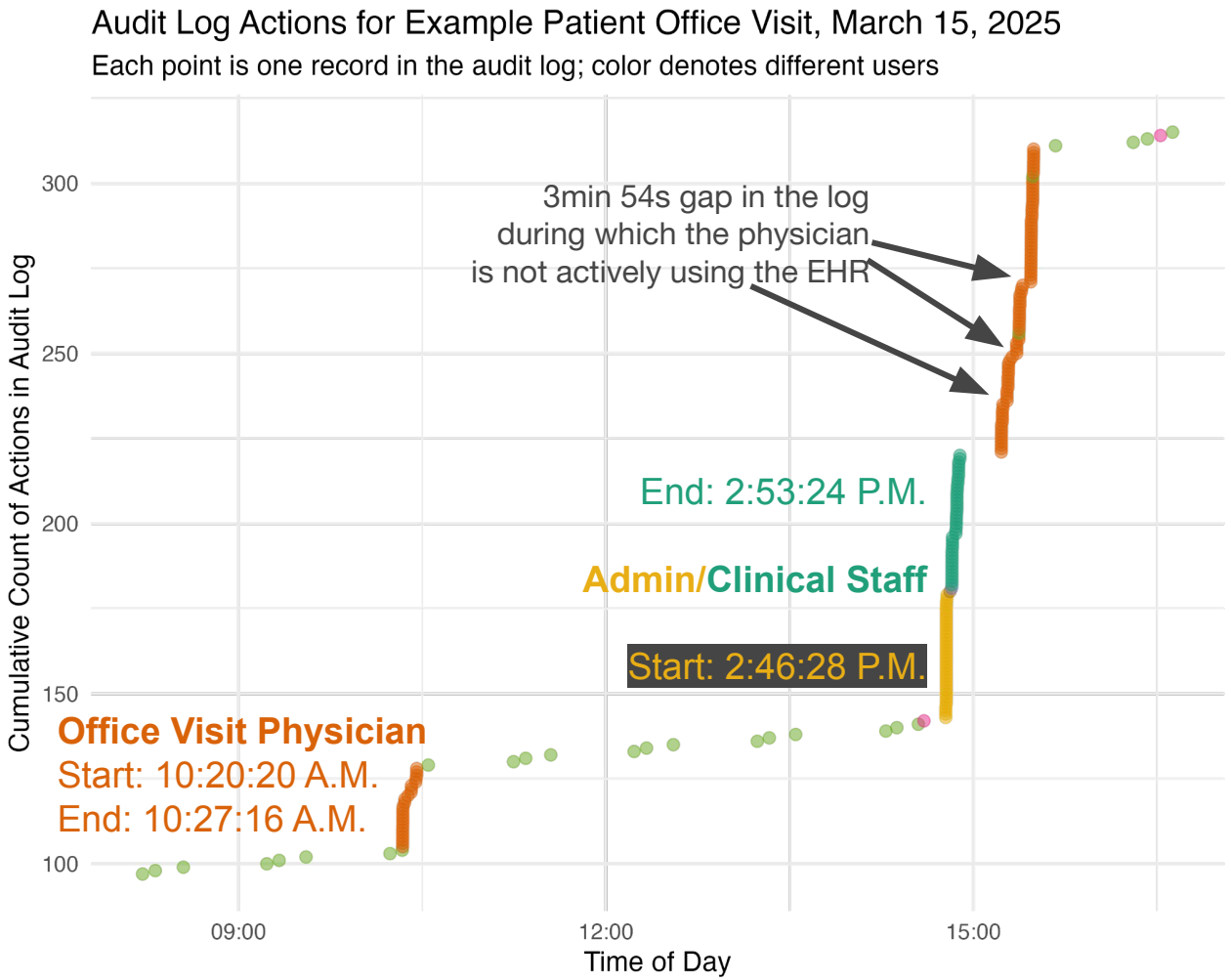
Staff time estimate from audit log activity:

6min 56s

Time spent before physician face-to-face estimate from audit log activity:

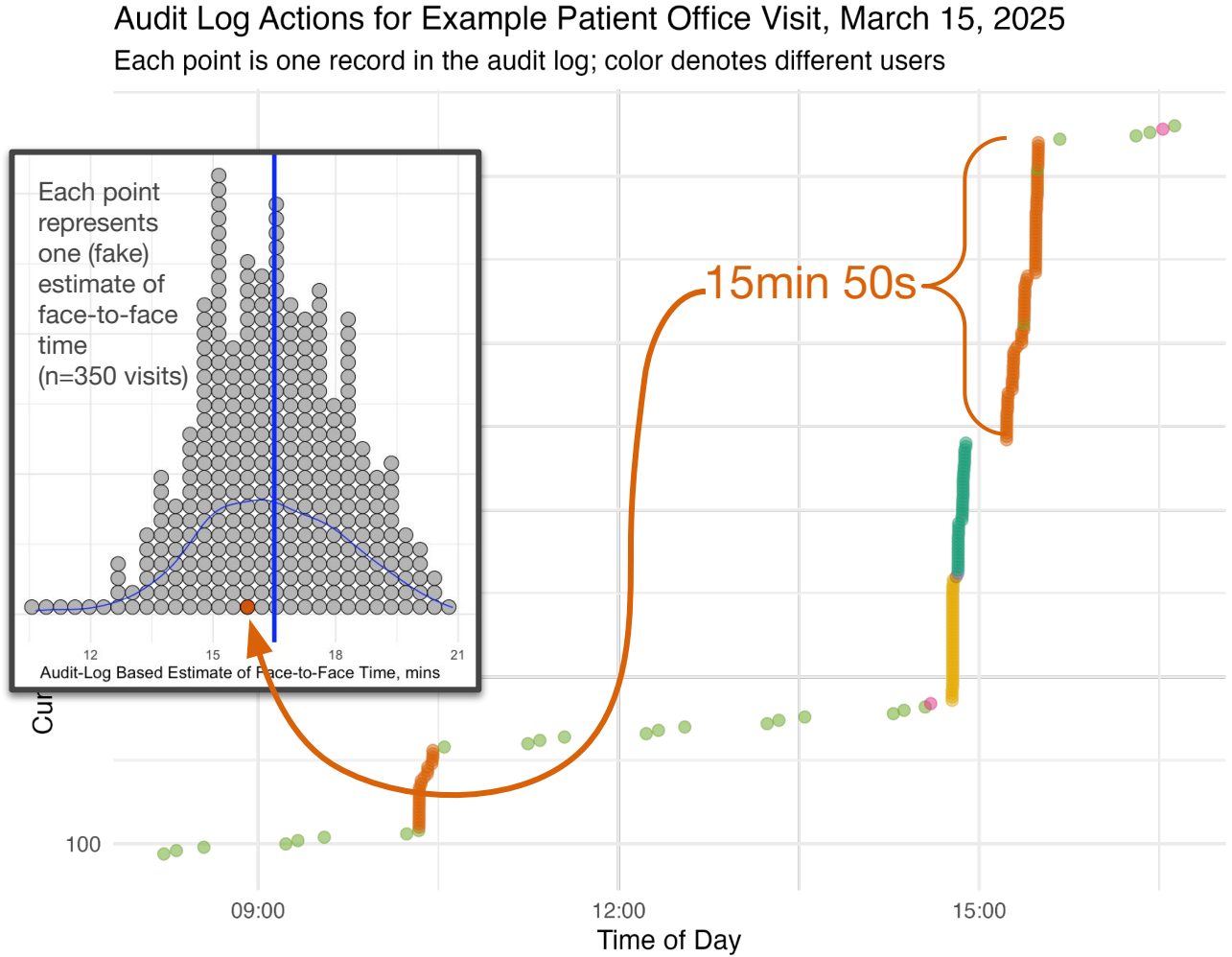
6min 56s

Total: 22min 46s



Example

Audit-log estimates of intraservice time can be analyzed collectively to get a sense of the overall average, variation, and reasonable bounds



Benefits of audit log-derived measures

Audit log data is systematically collected for all visits; can be organized by visit, patient, &/or user

Definitionally captures all activity in a given patient's chart (this is its core use case)

Can leverage start-points and end-points of "clusters" of activity to estimate time

- Can develop & apply rules for start/end points (e.g., specific action vs. any action)
- Can observe the *initiation* of specific workflows (e.g., registration)

Face-to-face time with the patient can be inferred and accounted for, as long as it is surrounded by some EHR use

Can combine context about the user, volume & nature of activity, and duration

Very easily de-identified while maintaining utility for measurement

Replicable across organizations (easier w/ same EHR vendor, but possible w/ different vendors)

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Drawbacks of audit log-derived measures

Hard to account for workflow, staffing, and teamwork differences across physicians and organizations (but we have the law of large numbers on our side)

Difficult (if not impossible) to capture *cognitive* intensity of work; this is a major potential issue for primary care specialties in particular

Can underestimate active time for activities that predominantly involve non-logged behavior (e.g., reading & writing notes)

Each CPT code will likely have slightly different ways to define start/stop times in the audit log (but we can observe these and design them in)

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Potential pilot study of physician & staff time standards

1. Select sample of time standards (e.g., operative note, 5 mins)
2. Extract logs for sample of procedures (n=150) to which that standard applies
3. Identify the specific logged events that correspond to the activity
   a. For example, all note-related events (see table, below)
4. Develop rules to determine start/end-points of specific activity in the log
5. Apply rules across procedure sample to estimate duration at scale
6. Construct distribution of activity durations to apply to CPT codes

visit_id	access_time	metric_id	metric_name	metric_desc
103	3/15/2025 10:21:29	60010	Pend clinical note	UCNNOTE_PEND
103	3/15/2025 10:22:59	60010	Pend clinical note	UCNNOTE_PEND
103	3/15/2025 10:27:14	60010	Pend clinical note	UCNNOTE_PEND
103	3/15/2025 15:23:30	60012	Clinical Note Signed	UCNNOTE_SIGN
103	3/15/2025 15:28:48	60012	Clinical Note Signed	UCNNOTE_SIGN
103	3/15/2025 15:29:27	60010	Pend clinical note	UCNNOTE_PEND
103	3/15/2025 15:29:28	34005	Notes viewed	VIEW_CLINICAL_NOTES
103	3/15/2025 15:29:33	60024	Clinical Note Signed as Visit Signed	UCNNOTE_SIGNATCE

Potential pilot study for audit-log service time estimates

1. Select a (small) sample of 5-10 CPT codes
    a. Record contemporaneous EHR activity (who, what, & when) that proxies start-points and end-points of pre/intra/post-service time
2. Extract audit logs for observed procedures *and* larger (but not directly observed) sample of the same procedure (set some minimum n like 150)
3. Match observation data to audit logs for observed sample to construct rules for start/end-points
4. Apply those rules to unobserved sample to compute service time estimates at scale
5. Construct distribution (mean, median, IQR, etc.) of pre/intra/post-service time estimates for observed and unobserved samples
    a. Compare to survey estimates

Thank you!

nca@umd.edu

This deck: https://go.umd.edu/ama_ruc_92525

More Information

Overview of Oracle Health (fmr. Cerner) log data: bit.ly/nca_cernlogs

Recent studies of documentation burden using log data: bit.ly/nca_doc

AMA-funded study of team-based ordering using log data: bit.ly/tword_hsr

AMA/Specialty Society RVS Update Committee **Tab 27**
Professional Liability Insurance Workgroup
Wednesday, August 13, 2025

Members Present: Bradley Marple, MD (Chair), Gregory Barkley, MD (Vice Chair), Megan Adamson, MD, Luke Barré, MD, Joseph Cleveland, MD, Daniel Duzan, MD, Jonathan Feibel, MD, Patrick Godbey, MD, Jonathan Kiechle, MD, Thomas Kintanar, MD, Doug Leahy, MD, Clarice Sinn, DO, G. Edward Vates, MD, Mary Walsh Sterup, OTR/L

I. Proposed Specialty Overrides for Low Volume Services

The standard process for deriving professional liability insurance (PLI) RVUs uses the most recent year's Medicare claims data to determine a specialty-weighted liability insurance premium as one of the main input into the PLI RVU formula. CMS also does a similar analysis to determine the specialty mix as part of the process for deriving the indirect practice expense portion of the PE RVUs. On occasion, a few erroneous claims with an incorrect CPT code number are present in the data CMS uses to derive PLI and indirect PE RVUs (meaning for those services the wrong specialty(ies) were used to derive the PE and PLI rvus for the impacted code). For services with a thousand or more claims, a handful of errant claims would have virtually no impact. However, for CPT codes that have very low volumes in the Medicare population, a few erroneous claims could have a large negative impact. To mitigate this issue, beginning in 2018, CMS first implemented a policy recommendation from the RUC to use single specialty override assignments for the assigned PLI risk premiums and indirect practice expense for very low volume services (those with an average of less than 100 Medicare utilization over the past 3 years). The current list, which includes over 2,000 codes, is available in the Proposed Rule addenda files.

For CY2026, AMA RUC staff performed an analysis to identify all eligible codes and put together a list of potential specialty overrides for each newly eligible service. Following the completion of the analysis and initial review, AMA Staff circulated the list to all RUC participants soliciting specialty society feedback on whether the suggested specialty override would be appropriate for each of the newly eligible service and received robust feedback. The specialty recommendations were integrated into an updated version of the spreadsheet shared with the PLI Workgroup.

The PLI Workgroup reviewed the updated proposed list of low specialty overrides for eligible services. The proposed list included 72 newly added services. The specialties had concurred with the initial proposed override for 68 of the 72 services. For 4 of the services, societies had uniformly suggested other single specialty overrides, which were reflected in the updated recommendations included in the PLI agenda materials. For codes, 22836, 22837 and 22838, AANS/CNS, NASS and AAOS recommended that the override should be orthopedic surgery. For code 62281, AAPMR and ASA recommended that the override should be physical medicine and rehabilitation.

The PLI Workgroup approved the proposed list of Expected Specialty Recommendations for Low Volume Codes for CY2026 NPRM Comment as included in the agenda materials with the 4 modifications recommended by societies. The updated document will be sent to CMS as part of the RUC comment letter.

II. Review of Draft RUC Comment Letter Section on PLI

The Professional Liability Insurance (PLI) Workgroup was asked to review and approve the PLI portion of the RUC's draft comment letter on the CMS *Proposed Rule* on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2026.

Approved by the RUC – September 27, 2025

The draft PLI section of the letter offers input below on two key areas of the PLI methodology in the Proposed Rule:

1) *Imputation Methodology*

   In the CY 2020 Proposed Rule, CMS had made improvements to acquire adequate premium data, however, the data set was not complete, and an imputation methodology had been developed. CMS proposed utilizing partial and total imputation (aka specialty crosswalks) to develop a more comprehensive data set when CMS specialty names were not distinctly identified for insurers in certain states. CMS continued to use the same approach for CY 2023 and CY2026, with the main change being to endeavor to augment existing data with additional data rather than ignoring and replacing the data collected from underrepresented specialties entirely. The RUC letter will provide recommendations on more appropriate crosswalks for several specialties for CY2026, the same recommendations it had also made in the CY2023 NPRM RUC comment letter (excluding any prior recommendations that CMS already adopted).

2) *Low Volume Service Single-specialty Overrides*

   This section of the letter provides an overview of CMS' low volume specialty override policy and makes recommendations on 72 additional services for CMS to add to the list for CY 2026. As this topic also applies to indirect practice expense, it will appear in the practice expense section of the RUC letter.

The Workgroup agreed that the draft content prepared by AMA RUC Staff was appropriate and did not have any suggested changes.

AMA/Specialty Society RVS Update Committee **Tab 28**
Practice Expense Subcommittee
September 24, 2025

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

I. Instrument Packs (EQ137-EQ138)

At the April 2025 meeting, the Practice Expense (PE) Subcommittee considered Tab 7 *Transoral Oropharyngeal Procedures* and noted that the history of the components of EQ137 *instrument pack, basic ($500-$1499)* and EQ138 *instrument pack, medium ($1500 and up)* may not be well understood by current participants. The PE Subcommittee agreed with the recommendation to continue to include the medium instrument pack EQ138 as a direct input for code 42808 *Excision or destruction of lesion of pharynx, without magnification, any method* but expressed the need to understand the background related to the formation of these packs. The Subcommittee agreed that AMA staff should research the issue of EQ137 and EQ138 instrument packs to share the history regarding how these packs were developed.

For the PE Subcommittee's information, AMA Staff provided an analysis from the RUC database comprising all 755 CPT codes that utilize the surgical instrument packages. There are 386 codes that contain EQ137 *instrument pack, basic ($500-$1499)* and 374 codes that contain EQ138 *instrument pack, medium ($1500 and up)*. Five codes use both packs. The recommendation for a Basic Surgical Instrument Package - $500 with cleaning time of 10 minutes and a Medium Surgical Instrument Package - $1,500 with cleaning time of 15 minutes was approved in March 2003. This action established standard surgical instrument packages with an approximate cost, recognizing that each society may have their own set of surgical instrument packs with different instruments.

The PE Subcommittee discussed the twenty year history of the surgical instrument packs and reviewed the Staff Note as informational.

II. New Business

The PE Subcommittee considered two tabs performed with moderate sedation at this meeting, Tab 05 *Intraosseous Fiducial Marker Placement* and Tab 07 *Sacroiliac Joint Arthrodesis*. This requires review and confirmation that duplicate PE inputs do not exist; in doing so, the Subcommittee questioned the rationale for including a sterile gown but no mask in the moderate sedation pack (SA044). The PE Subcommittee expressed the need to understand the background related to the formation and composition of this pack. **The PE Subcommittee agreed that AMA staff will research the issue of SA044 *pack, moderate sedation* to share the history regarding how this pack was developed.**

III. Practice Expense Recommendations for CPT 2027

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

Tab	Title	PE Input Changes	Consent Calendar
4	Ablation Therapy – Bone Tumors	No Direct PE Inputs recommended – Facility-only Add-on service	X
5	Intraosseous Fiducial Marker Placement	Modifications	
6	Computer Assisted Surgical Navigation	No Direct PE Inputs recommended – Facility-only Add-on service	X
7	Sacroiliac Joint Arthrodesis Revision	Modifications	
8	Cardiac Contractility Modulation	Modifications	
9	Diaphragm Repair	Standard 90-day global inputs recommended	X
10	Endoscopic Submucosal Dissection, Upper and Lower GI	No Change	
11	Congenital Duodenal Obstruction Repair	Standard 90-day global inputs recommended	X
12	Irreversible Electroporation of Tumor – Pancreas	Standard 90-day global inputs recommended	X
13	Percutaneous Lumbar Decompression	Standard 90-day global inputs recommended (62287) Affirming January 2025 RUC recommendations (62XX0, 62XX1)	X
14	Rotational Vestibular Assessment	Modifications	
15	Intracoronary Drug Delivery Balloon Services	No Direct PE Inputs recommended – Facility-only services	X
16	Laser Treatment for Inflammatory Skin Diseases	No Change	
17	Lactation Care Services	Modification	

Tab	Title	PE Input Changes	Consent Calendar
18	Arthroplasty – Shoulder	Standard 90-day global inputs recommended	X
19	Arthroplasty – Hip	Standard 90-day global inputs recommended	X
20	Arthroplasty – Knee	Standard 90-day global inputs recommended	X
21	Transcatheter Aortic Valve Replacement	No Survey – Societies submitting a code change application to CPT	X
22	Appendectomy	No Survey – Societies submitting a code change application to CPT	X
23	Stereotactic Computer-Assisted Volumetric Navigational Procedures	No Change	
24	Laminectomy	Standard 90-day global inputs recommended	X
25	Injection Anesthetic Agent	No Change	

AMA/Specialty Society RVS Update Committee **Tab 29**
Relativity Assessment Workgroup
September 25, 2025

Members Present: Doctors Amr Abouleish (Chair), Gregory Nicola (Vice Chair), Dale Blasier, Audrey Chun, Beth Drolet, Jeffrey Edelstein, Alexandra Flamm, Harlivleen Gill, MBA, RDN, Gregory Harris, James Holmes, Gwenn Jackson, Kevin Kerber, Kyle Richards, Clarice Sinn, Michael Sutherland, John Thompson, G. Edward Vates and Richard Weiss.

I. Review Action Plans

A. DNU RUC Flag

At the January 2025 meeting the Relativity Assessment Workgroup determined that it should reexamine the other specific flagged codes that are currently flagged in the RUC database, in detail by reviewing an action plan from the specialty societies. The Workgroup spread this review over a few meetings. Once a code is reviewed by the RAW under this flag, the code would not be continued to be reviewed under this flag.

The Workgroup reviewed action plans to determine if the DNU specific flagged codes should be maintain the flag, remove the flag, or other. The goal will be to find a way to resolve the issue that led to the flag, if possible. The Workgroup noted if a code is on the new technology/new services list already scheduled for review, that those codes be maintained on that list and address the new technology/new service and DNU flag at the same time. At the September 2025 meeting, the Workgroup reviewed action plans for 16 services flagged as DNU. **The Workgroup recommends the following:**

CPT Code	Recommendation
22870	Remove DNU flag. The quality and consistency of the survey data, the stability in utilization, and the recency of the review do not support the continued need for the DNU designation.
33419	Remove DNU flag. CPT code 33419 was surveyed. The flag originated because of the time recommendation was based on an expert panel. The time was a recommendation informed by a valid survey of both the add-on and its base code; the time was reduced from the survey median rather than increased; and was in-line with comparator codes in actual time and IWPUT.
33509 35600	Remove DNU flag. The codes only account for the additional intra-service work associated with the upper extremity harvest procedure, are low volume services and reflect procedures where since their implementation have not had any change in the work associated with them.
34702	Maintain flag.
61889 61891 61892	Maintain flag. Review April 2028 when up for review on the new technology/new services list.
64633	Remove DNU flag. The RUC recommended work RVU was determined by a valid method and CMS further adjusted the work RVU. **The only flag should be "CMS did not accept the RUC recommendation."**
66174	Maintain flag.
67141 67145	Maintain flag.

CPT Code	Recommendation
69706	Maintain flag. Low utilization.
93582	Remove DNU flag. The crosswalk correctly indicates the appropriate intra-service time and intensity of this rare procedure.
97607 97608	Maintain flag. Review in 1 year (September 2026) to examine growth and determine if a valid survey could be conducted.

B. RUC Flag Review

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

C. CMS/Other Source – Medicare utilization over 20,000

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

CPT Code	Recommendation
73201	**Survey 73200, 73201 & 73202 for January 2026 RUC meeting.**
G0270	Refer G0270 and G0271 to the CPT Editorial Panel for creation of Category I codes to describe MNT services following a second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease).
G0453	Refer to CPT May 2026 to revise 95940 to include the services currently reported with G0453. There is not a current Category I CPT code to report intraoperative neurophysiology monitoring services outside the operating room, per patient, per 15 minutes.
G2083	Refer G2082 and G2083 to CPT May 2026 to create Category I codes to report these services.
G3002	Refer G3002 and G3003 to CPT to be considered under the CPT Value-Based Care Workgroup.

D. Harvard Valued – Medicare utilization over 30,000

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

CPT Code	Recommendation
31525	Maintain and **notify CMS** again of the possible misreporting of CPT code 31525 as it is being reported by one physician performing 82% of these services (based on 2023 Medicare Physician & Other Practitioners by Provider and Service data). Review again at the RAW in 2 years (September 2027).
36248	Refer to CPT Assistant for the specialty societies to develop an article to provide additional guidance for appropriate coding and utilization of CPT 36248. Code 36248 is designated for use when an additional selective catheterization of a second or third-order vessel is performed. This code should apply only to named vessels, not to branches arising from those vessels.

E. High Volume Growth

In April 2025, the Workgroup identified nine codes with Medicare utilization of 10,000 or more that has increased by at least 100% from 2018 through 2023. The Workgroup requested that the specialty societies submit action plans for codes 31525, 31627, 33340, 36465, 65820, 92978, 93355, 95251 and 96127 for September 2025. **The Workgroup reviewed the action plans and recommends:**

CPT Code	Recommendation
31525	Maintain and **notify CMS** again of the possible misreporting of CPT code 31525 as it is being reported by one physician performing 82% of these services (based on 2023 Medicare Physician & Other Practitioners by Provider and Service data). Review again at the RAW in 2 years (September 2027).
31627	Refer to CPT Editorial Panel May 2026 to create a new code that represents the use of robotics which may be the cause of the increase in reporting of CPT code 31627.
33340	**Survey January 2026.**
36465	**Survey January 2026 along with the family of services as identified by the specialty societies** (CPT codes **36465**, 36466, 36470, 36471, 36473, 36474).
65820	Refer to CPT Feb 2026. Create new Category I CPT code specific for stand-alone performance of goniotomy in adults and to modify the existing CPT 65820 to define it for performance in children.
92978	**Survey January 2026 along with the family of services as identified by the specialty societies** (CPT codes **92978** and 92979).
93355	**Survey January 2026.**
95251	**Survey January 2026 along with the family of services as identified by the specialty societies** (CPT codes 95250, 95249 and **95251**).

CPT Code	Recommendation
96127	Maintain and remove from screen. There is evidence that more recent cohorts aging into Medicare seek significantly more counseling and psychotherapy than prior cohorts. The demand for mental health services is increasing among Medicare beneficiaries, partly due to the aging population, the impact of events like the COVID-19 pandemic, and a greater awareness and understanding of mental health issues. Code 96127 is routinely used to report administration of a depression inventory, and its increased use under Medicare is consistent with the increased use of counseling and psychotherapy by more recent Medicare cohorts. Additionally, more clinical guidelines support the administration of brief emotional/ behavioral assessments represented by code 96127, which has supported more widespread adoption of such instruments in routine screening in primary care.

F. Surveyed by one specialty and now performed by a different specialty

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

CPT Code	Recommendation
16020	Maintain and remove from screen. Identification of a top specialty is not straightforward, it is limited by the types of CMS specialty codes, and that membership organizations can include professionals from multiple disciplines. Additionally, the utilization just exceeded 10,000 which may be difficult to obtain a valid number of survey responses.
25605	Submit action plan for January 2026 to determine if this code should be changed to a 000-day global period and resurveyed since it is reported with Modifier -54 *Surgical Care Only: When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management* 90% of the time.
62368	Maintain and remove from screen. At the Feb 2011 RUC meeting, CPT code 62368 was not surveyed but was reviewed and crosswalked to 62369 when this family was surveyed (62367, 62369 and 62370) which included anesthesiology and pain management.
64505	Remove from screen. CPT code 64505 was never surveyed for work and the physician time indicated was listed for PE review purposes only.
73580	Maintain and remove from screen. Data demonstrates that a small number of clinicians in each specialty are reporting code 73580.
77261	Maintain and review after 3 years of data are available (Sept 2028). CPT 2026 coding changes should address this issue, and dermatologists should no longer report 77261-77263 codes for stereotactic radiation therapy (SRT).
86077	Refer to CPT May 2026 to revise CPT code 86077 to better capture the spectrum of physician work associated with different, but typical, patient scenarios and to potentially expand the blood bank physician services code family to capture the physician work associated with the interpretation and incorporation of molecular studies into the pathology report.
95144	Refer to CPT Assistant to develop an article to clarify the correct reporting of this service.
96521	Refer to CPT Assistant to develop an article to clarify the correct reporting of this service.

G. Contractor-Priced High Volume

In April 2025, the Workgroup identified one code with 2023 Medicare utilization over 10,000 and Medicare status of "C" contractor priced. The Workgroup requested an action plan for G0340 for September 2025. **The Workgroup reviewed the action plan and recommends that the RUC request that CMS delete G0339 *Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment* and G0340 *Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.*** Currently only 17 centers in 11 states offer robotic radiosurgery. Reviewing the 234 physicians reporting this code in 2023, the specialty notes that 68 physicians no longer offer robotic radiosurgery and 20 physicians retired. CPT code 77373 *Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions* is available to report in lieu of G0339 and G0340. **The Workgroup will review in September 2026 if CMS did not propose to delete for CPT 2027.**

H. Category III High Volume

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

CPT Code	Recommendation
0207T	Maintain. Does not yet meet requirements for Category I due to lack of peer review literature/research. Review in 3 years (Sept 2028).
0480T	Review action plan in April 2026, when 2024 Medicare claims data are available.
0486T	Maintain. Industry submitted CCA for Sept 2025 CPT meeting, but it was withdrawn due to lack of widespread use criteria. Review in 3 years (Sept 2028).
0512T	Maintain. Does not yet meet requirements for Category I due to lack of widespread use. Review in 3 years (Sept 2028).
0627T	Maintain. Does not yet meet requirements for Category I. Review in 3 years (Sept 2028).
0640T	Maintain. Does not yet meet requirements for Category I due to lack of widespread use. Review in 3 years (Sept 2028).
0753T	Maintain. Does not yet meet requirements for Category I. Review in 3 years (Sept 2028).

I. CPT Assistant Article Analysis

Gastrostomy Tube Replacement (43762 & 43763)

In 2017, CMS identified these codes via the 000-Day Global Typically Reported with an E/M screen. In January 2018, the RUC recommends that these codes be reviewed by the Relativity Assessment Workgroup in two years to examine utilization data to determine if 90% of 43760 are directed toward 43762 and 10% to 43763, as predicted. These data should also indicate if these codes are typically reported with E/M services and if the global period assignment should remain 000. In January 2022, the Workgroup reviewed these services and determined that the utilization split is as was projected. Additionally, these services are not typically reported with office visits, hospital visits or emergency department visits and the 000-day global period assignment is appropriate. The specialty society voiced concern with the utilization by providers that are not expected to perform this surgical procedure. It is

possible that, because 2019 was the first year for this new low volume code, that there may be a misunderstanding of this procedure resulting in misreporting. Therefore, the specialty societies indicated they would develop a CPT Assistant article that describes correct reporting of 43763 and contrasts this procedure with 43762 and other codes for g-tube placement (eg, 43246, 49440). The Workgroup recommended that CPT codes 43762 and 43763 be maintained/removed from this screen and referred to CPT Assistant to describe scenarios when each of these services should be reported.

A CPT Assistant article was published to clarify the appropriate reporting of 43763 by surgeons. Code 43763 is typically performed under general anesthesia. However, 43763 is still being reported by nurse practitioners in the nursing facility and office, 42.5% (2023 Medicare utilization data). Data from the Medicare Physician & Other Practitioners shows one nurse practitioner in Florida as the dominant provider of 43763, performing 816 of 1,282 services in 2022 and 844 of 1,262 services in 2023. The specialty societies submitted an action plan to discuss what action, if any, should occur for these services.

In September 2025, the specialty societies indicated that CPT code 43763 is being reported by two providers and that these services should be maintained and CMS notified of possible misreporting. **The Workgroup recommends that the RUC inform CMS of the possible misreporting of 43763 to address through program integrity and review in 3 years (Sept 2028).**

J. Work Neutrality (CPT 2023)

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

CPT Code	Issue	Recommendation
93653 93654 93655 93656 93657 93613 93621 93662	Cardiac Ablation	Remove from screen. The sum of actual 2023 work RVUs (2.4 million) was work neutral compared to the sum of the 2023 source projected work RVUs (2.7 million) but just not as large of a savings as expected.
92065 92066	Orthoptic Training	Refer to CPT Assistant to develop a Q&A discussing the circumstances in which each code should be billed. Review again when on the new technology list in April 2027.
50080 50081 50432	Percutaneous Nephrolithotomy	Review in 3 years (Sept 2028) to examine overall utilization/work RVUs/work neutrality and review the shift in simple versus complex. The estimates indicated that the simple code 50080 would be reported 29% of the time and the complex code 50081 would be reported 71% of the time. However, the actual 2023 reporting was 20% of the simple code 50080 and 80% of the complex code 50081.
76881 76882 76883	Neuromuscular Ultrasound	Review in 3 years (Sept 2028).

K. Services Reported Together 75% or More

In April 2024, the Relativity Assessment Workgroup identified code pair 13152/17311 as performed by the same physician on the same date of service 75.4% of the time based on 2022 Medicare Utilization data. The Workgroup requested action plans for September 2024. In September 2024, the Workgroup recommended to review in 1 year (September 2025) to determine if 13152 and 17311 are still being reported together more than 75% of the time. The 2023 data indicates that 13152 is reported with 17311 77.4% of the time. The Workgroup requests an action plan for September 2025 to determine if specific code bundling solutions should occur for this code pair.

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

In September 2025, the Workgroup reviewed the action plans and recommends:

CPT Code1	CPT Code2	Recommendation
13152	17311	Remove from screen. Mohs surgery 17311 is the primary procedure and 13152 is the repair following the Mohs surgery. There is no overlapping work, pre or post-time or practice expense for 13152 and 17311. After 17311 is performed, 60-120 minutes pass before the tumor is cleared as indicated by lab results and 13152 is performed. Thus, the patient will have all new and separate pre-service activities provided in a separate room. Also, the MPPR applies to these services if reported with another service.
55874	55876	Refer to May 2026 CPT Editorial Panel to create a code bundling solution.
63015	22600	Submit an action plan for January 2026. Explain what other codes, if any, would be affected if 63015 and 22600 were bundled.

L. RUC Referral to CPT (G0396)

Alcohol/Substance Misuse Structured Assessment and Brief Intervention (G0396)

In October 2017, code G0396 was identified via the CMS/Other codes with Medicare utilization of 30,000 or more screen. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially remove "screening" from 99408 and 99409 to "assessment" to mirror G0396. At the February 2018 CPT meeting, the Panel postponed until time uncertain this request to revise codes 99408-99409 to identify assessment of alcohol and/or substance abuse. As a rationale for postponement, the Panel indicated that the service described in this application did not meet the General Criteria for Category I because the proposed service is not unique or well defined and does not describe a service that is clearly identified and distinguished from existing services already described in CPT by other codes. The Panel's additional rationale for postponement of this item was to allow the relevant specialty societies an opportunity to submit a new code change application to address the differences between assessment and screening services.

A code change application CCA has not been submitted to date, thus the specialty societies were asked to submit an action plan for September 2025 on how to address this service.

The specialty societies requested, and the Workgroup recommends referring this issue to the CPT February 2026 meeting to formally request that "screening" be replaced with "assessment" in the descriptors for CPT codes 99408 and 99409 to eventually replace G0396 and G0397.

II. Discussion of Potential New Screens

A. RUC Review > 20 years ago with Medicare Utilization over 1 million

In April 2025, the Relativity Assessment Workgroup chair noted a possible screen for services that have not been reviewed by the RUC in the last 20 years ago (prior to 2006) with 2023 Medicare utilization over 1 million. AMA staff identified three codes: 17110, 84165 and 99291.

The Workgroup reviewed the data for these three codes and removed CPT code 84165 from the screen because on the MFS, CPT 84165 exists solely as a -26 professional component. This code does not have RVUs for either the global or TC components. When the RAW reviews utilization, it uses the global+26 total. However, in the case of CPT code 84165, only the -26 professional component volume should be considered. Therefore, CPT code 84165 was removed from this screen, as the -26 professional component utilization is 603,925, which falls below the 1 million threshold. **The Workgroup requested that the specialty societies submit action plans for codes 17110 and 99291 for review at the January 2026 meeting.**

The Workgroup speculated whether this screen would identify too many codes in the future and be burdensome to address if continued. AMA staff noted that based on the 2023 utilization data, very few codes would be identified per year.

Year	Possible Number of Codes	RUC Review Year
2026	0	2006
2027	6	2007
2028	1	2008
2029	3	2009
2030	5	2010

The Workgroup indicated it will discuss future application of this screen at the January 2026 Relativity Assessment Workgroup meeting.

B. High Intra-Service Work Per Unit of Time (IWPUT)

In April 2025, the Relativity Assessment Workgroup chair noted a possible screen to examine the IWPUT data to determine if it would be an appropriate new screen. The Workgroup last reviewed the High IWPUT screen in 2008. The High IWPUT screen was based on services with a total Medicare utilization of 1,000 or more with an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in the identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate.

For September 2025, AMA staff examined the data and identified 37 codes with an IWPUT greater than 0.14 and 2023 Medicare utilization over 1,000. Eight of these services were either reviewed via the last identification of this screen or were recently reviewed for CPT 2026.

The Workgroup noted that ZZZ and 000-day global codes should also be excluded as they were not included in the first iteration of the high IWPUT screen. After removing the ZZZ and 000-day global

codes, 9 codes remained, all which were reviewed since the first iteration of this screen in 2008 and the RUC applied a thorough review of the IWPUT during those valuations. The Workgroup also noted that 7 codes are performed by ophthalmology, which by the nature of their services typically have shorter intra-service time and many post-operative office visits. **The Workgroup determined rerunning the high IWPUT did not identify any potentially misvalued services to examine further.**

C. CMS Inpatient Only List – Site of Service Anomaly Identification

In April 2025, during new business at the RUC meeting, another potential screen was identified to investigate. A RUC member requested that the RAW look at the annual CMS inpatient only list for services performed in the outpatient setting. Annual review of the data instead of three years may promptly confirm site of service accuracy. The Chair of the RAW stated that the original intent of using three years of outpatient data was to ensure that there was truly a shift in site of service from inpatient to outpatient. However, in using this method, a few codes under review at this September 2025 meeting were delayed in review as the removal from the inpatient only list led to an immediate transition to outpatient. It was suggested that if the data is overwhelmingly outpatient after one year, it would indicate that an immediate re-review should occur as the service had clearly transitioned to outpatient This item was referred to the RAW for further discussion at the September 2025 meeting.

AMA staff reviewed *Addendum E. HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2020-2025 from the OPPS* to see which codes were removed from the Inpatient Only list and if the year it was removed indicated a transition from inpatient to outpatient.

The data did not show a significant shift to the outpatient setting the year in which a code was removed for all but one code.

- For codes removed from the inpatient only list for CY 2020, no code indicated outpatient in the year in which it was removed. Total hip arthroplasty, CPT code 27130, was performed primarily in the outpatient setting one year later in 2021.

- For codes removed from the inpatient only list for CY 2021, total shoulder arthroplasty, CPT code 23472, indicated a typical outpatient setting in the year it was removed from the inpatient only list 2021.

- For codes removed from the inpatient only list for CY 2022, the codes that were removed from the inpatient only list were only due to deletion from CPT for 2022.

- For codes removed from the inpatient only list for CY 2023, the codes removed from the list were either deleted from CPT or the utilization is so low that the fluctuation may be an outlier, and it would also not meet the utilization threshold of 10,000 for the site of service anomaly screen.

- No codes were removed from the inpatient only list for CY 2024.

- Only one code was removed from the inpatient only list for CY 2025. The 2025 site of service data will not be available until late 2026.

July 15, 2025, Update: In the Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule for 2026. CMS proposed to eliminate the entire Inpatient Only List.

Eliminating the Inpatient Only (IPO) List
CMS is proposing to phase out the IPO list over a 3-year period, beginning with removing 285 mostly musculoskeletal procedures for CY 2026. CMS believes that the evolving nature of the practice of medicine allows more procedures to be performed on an outpatient basis with a shorter recovery time. This proposal would allow for these services to be paid by Medicare in the hospital outpatient setting when determined to be clinically appropriate, giving physicians greater flexibility in determining the most appropriate site of service.

In September 2025, the Workgroup discussed the pending CMS proposal to phase out the CMS inpatient only list. The Workgroup would like to discuss further the concept of using some threshold (eg, 60% outpatient) to determine that the codes should be re-reviewed after one year of claims data versus waiting for three years of data to confirm that >50% of services are reported outpatient. CMS decision to remove or retain the inpatient list will also be available before the January 2026 meeting. **The Workgroup determined that it would continue this discussion at the January 2026 meeting.**

III. 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.