

October 13, 2025

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

Subject: RUC Recommendations

Dear Administrator Oz,

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare & Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2027* and to existing services identified by the RUC's Relativity Assessment Workgroup and CMS.

Enclosed are the RUC recommendations for all the CPT codes reviewed at the September 24-27, 2025, RUC meeting.

CPT 2027 New and Revised Codes – October 2025 RUC Submission

The RUC submits work value and/or practice expense inputs for 54 new/revised/related family CPT codes for *CPT 2027* from the September 2025 RUC meeting.

Existing Services Identified by RUC and CMS for Review

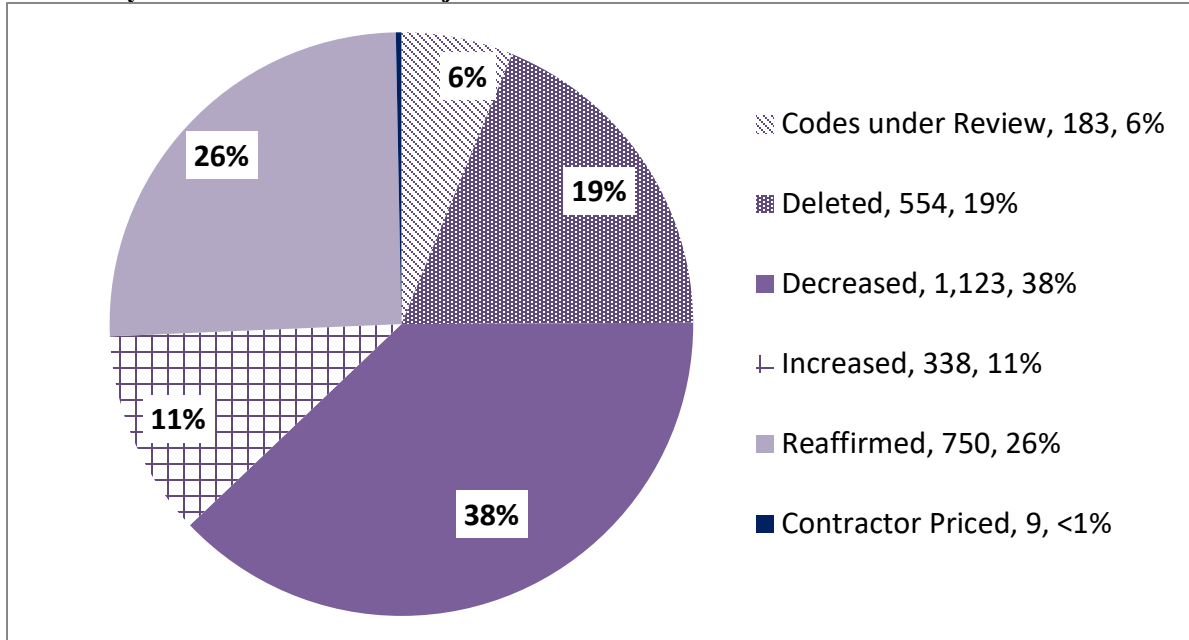
In addition to the new/revised CPT code submission, the RUC submits recommendations for 24 services identified by the RUC or CMS as potentially misvalued and reviewed at the September 2025 RUC meeting (10 of which are referrals to the CPT Editorial Panel for revision).

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since 2006, the RUC has identified 2,957 potentially misvalued services through objective screening criteria and has completed review of 2,774 of these services. The RUC has reviewed approximately 95% of the Medicare Physician Payment Schedule allowed charges. Codes that have not been reviewed are low volume and represent a minimal amount of allowed charges. The RUC has recommended that 57% of the services reviewed be decreased or deleted (Figure 1). The RUC has worked vigorously to identify and address mis-valuations in the RBRVS through the provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS in a concerted effort to address potentially misvalued services.

Figure 1: AMA/Specialty Society RVS Update Committee (RUC) Potentially Misvalued Services Project

Potentially Misvalued Services Project



Source: American Medical Association

Laryngoscopy (31525)

In September 2024, the RAW reviewed 31525 *Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn* via the Reported Together 75 Percent or More screen. The 2023 Medicare utilization showed that CPT code 31525 was reported with CPT code 31231 80 percent of the time, and CPT code 31325 was reported with CPT code 69210 75 percent of the time. Therefore, these codes appeared on the screen the RAW reviewed to determine if a code bundling solution was necessary. The specialty societies indicated that although the Medicare utilization shows that these services are billed together, the publicly available CMS [2022](#) and [2023 Medicare Physician & Other Practitioners - by Provider and Service](#) showed that one Otolaryngology practice located in California is the top physician for all three of these codes.

Therefore, the specialty society indicated to the RUC that, based on the lack of clinical justification to report these services together frequently, they believe it is appropriate to maintain these codes as currently described. There is no clinical justification for combining these codes, and it seems the billed together data is likely being driven by a single practice in the country.

The specialty societies notified CMS of possible misreporting of these services prior to the RUC review of these services under this screen. On October 15, 2024, the RUC submitted recommendations and notified CMS of the possible misreporting of CPT code 31525 based on the 2022 data.

In the NPRM for 2026, CMS did not acknowledge that they received the RUC notification of possible misreporting of CPT code 31525. In its August 21, 2025, comment letter on the Proposed Rule for 2026, the RUC requested that CMS address the possible misreporting of 31525 in the Final Rule for 2026.

In September 2025, CPT code 31525 also appeared on the Harvard valued with Medicare utilization over 30,000 screen and the high volume growth screen. **The RUC would again like to notify CMS of the possible misreporting of CPT code 31525, as it is being reported by one physician performing 82 percent of these services based on 2023 Medicare Physician & Other Practitioners by Provider and Service data. Please see specific details in folder 27 Other RAW Related Recommendations.**

Image-guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340)

In April 2025, the Relativity Assessment 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. In September 2025, the Workgroup reviewed the action plan and recommended 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 these codes in 2023, the specialty society notes that 68 physicians no longer offer robotic radiosurgery and 20 physicians retired. Additionally, 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. **The RUC requests that CMS delete G0339 and G0340. Please see specific details in folder 27 Other RAW Related Recommendations.**

Gastrostomy Tube Replacement (43762 & 43763)

In 2017, CMS identified CPT codes 43762 *Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract* and 43763 *Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract via the 000-Day Global* Typically Reported with an E/M screen. In January 2018, the RUC recommended 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 in June 2022, 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 Relativity Assessment Workgroup reviewed this issue to see if the CPT Assistant article was effective. 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 RUC would like to notify CMS of the possible misreporting of CPT code 43763. Please see specific details in folder 27 Other RAW Related Recommendations.**

Practice Expense Subcommittee

The attached materials include direct practice expense input (clinical staff, medical supplies and equipment) recommendations for each code reviewed. As a reminder, cost estimates for proposed new clinical staff types, medical supplies and medical equipment (not listed as part of the CMS labor, supply, and equipment lists) are based on provided source(s), such as paid invoices and may not reflect the wholesale prices, quantity, cash discounts, and prices for used equipment or any other factors that may alter the cost estimates. **The RUC shares this information with CMS without making any recommendations on pricing.**

High-Cost Disposable Supplies

The RUC considered Tab 7 Sacroiliac Joint Arthrodesis at its September 2025 meeting and recommends a new high-cost supply input (i.e., priced more than \$500), *Dorsal SI joint articular fixation device*, with a cost estimate of \$14,451.00 for CPT code 27279. In addition, the specialties submitted an invoice to support a price increase from \$11,500 to \$12,500 for existing high-cost disposable supply item, SD356 *Dorsal SI Joint Arthrodesis Implant*, for CPT code 27278. This code is an example of where the total Medicare non-facility payment (\$11,805.18) is *less than* the total direct PE non-facility costs (\$12,069.40). Tab 7 illustrates the urgency to support the RUC recommendation to separately code and pay for high-cost disposable supplies.

For two decades, **the RUC has recommended that CMS separately identify and pay for high-cost disposable supplies (i.e., priced more than \$500) using appropriate Healthcare Common Procedure Coding System (HCPCS) supply codes.** It is notable that in the CY2026 Proposed Rule, CMS requested comment on the creation of G-codes to describe the use of high-cost supplies.

The RUC continues to support its recommendation and urges CMS to address the outsized impact that high-cost disposable supplies have within the current practice expense relative value unit (PE RVU) methodology. The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. The practice expense methodology derives code-level indirect practice expense in part from code-level direct practice expense inputs, including high-cost disposable supplies. When CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service, which is subsidized by the broader specialty and all other physicians and qualified healthcare professionals. If high-cost supplies were paid separately with appropriate HCPCS codes, the disproportionate indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services. **The RUC contends that the outsized impact that high-cost disposable supplies have within the current PE RVU methodology must be addressed immediately as the influx of new technology and high-cost supplies continues.**

The 2026 Proposed Medicare Physician Payment Schedule includes 94 medical supply items currently embedded in codes with a purchase price of more than \$500. These high-cost medical supplies represent \$1.53 billion in direct costs for the 2026 MFS and 21 percent of all direct practice expense medical supply costs in the non-facility setting. *Please see the analysis of high-cost supplies over \$500 in folder 26 Other Practice Expense Related Recommendations.*

Moreover, the RUC emphasizes the importance of accurate pricing of high-cost supplies. It is CMS' responsibility, as required by law, to ensure the accurate pricing of the high-cost supply items. Accurate pricing of the 94 high-cost supplies is critical and should be based on a transparent process. The RUC notes that invoices for high-cost supplies are required at the time of submission but should be reviewed annually to ensure accuracy.

The RUC strongly supports its long-standing RUC recommendation that CMS separately identify and pay for high-cost disposable supplies priced more than \$500 using appropriate Healthcare Common Procedure Coding System (HCPCS) supply codes. The pricing of these supplies should be based on a transparent process whereby items are reviewed and updated on an annual basis.

Office and Hospital Visits Included in Codes with a Surgical Global Period

The RUC strongly believes that the changes in valuation of the office and hospital E/M visits be incorporated into the visits in the surgical global periods. Since CMS did not apply the office E/M visit increases to the visits bundled into global surgery payment, it is disadvantaging specific specialties. An example of the shortcomings of this policy decision became apparent during discussion of CPT code 67141 *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy* (RUC recommended work RVU = 2.53 and 2-99213 office visits) at the October 2020 RUC meeting. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and aligns with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes were being valued too low considering that office visits for the surgical global period were not going to be increased to the 2021 office E/M codes. Considering that the 99213 office visit is valued at 1.30 RVUs two 99213 office visits are valued higher than the 2.53 value of this code. Therefore, the CMS policy is disadvantageous to the eye surgeons and an example of shortcomings and rank order abnormalities the flawed policy creates. The Agency's position implies that the physician work for office visits is not the same when performed in a surgical global period, which is an inaccurate assumption.

The RUC recommends that CMS apply the office visit and hospital visit valuation changes uniformly across all services and specialties. CMS should not hold specific specialties to a different standard than others. The RUC urges CMS to apply the office visit and hospital visit changes to the office and hospital visits included in surgical global payment, as it has applied historically.

Enclosed Recommendations and Supporting Materials:

- RUC Recommendation Status Report for New and Revised Codes for *CPT 2027*.
- RUC Recommendation Progress and Status Reports for services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.
- Physician Time File – A list of the physician time data for each of the CPT codes reviewed at the September 2025 RUC meeting.
- Pre-Service and Post-Service Time Packages Definitions – The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.
- Professional Liability Insurance (PLI) Crosswalk Table – The RUC has committed to selecting appropriate PLI crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.
- BETOS Assignment Table – The RUC, for each meeting, provides CMS with suggested BETOS classification assignments for new/revised codes. Furthermore, if an existing service is reviewed and the specialty believes the current assignment is incorrect, this table will reflect the desired change.
- Utilization Data Crosswalk – A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2027 conversion factor increase.
- New Technology List and Timeline – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 925 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.
- RUC Recommendations on Modifications to Visits in the Global Period – This includes changes in work RVUs and time by incorporating the increase of office visits and hospital visits in the surgical global periods.

Administrator Oz
October 13, 2025
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We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at Sherry.Smith@ama-assn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Ezequiel Silva III".

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

Enclosures

cc: RUC Participants
Perry Alexion, MD
Lindsey Baldwin
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